HEALTH SECURITY ACT OF 1993

HEARINGS

BEFORE THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

NOVEMBER 9 AND 18, 1993

Serial No. 103–27

Printed for the use of the Committee on Post Office and Civil Service

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HEALTH SECURITY ACT OF 1993

TUESDAY, NOVEMBER 9, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, DC.

The committee met, pursuant to call, at 1 p.m., in room 311, Cannon House Office Building, Hon. William L. Clay (chairman of the committee) presiding.

Members present: Representatives Clay, McCloskey, Ackerman, Sawyer, Norton, Bishop, Hastings, Myers, and Morella.

Mr. CLAY. The committee will come to order. This afternoon the committee begins its consideration of the Health Security Act of 1993, President Clinton's bill to reform the Nation's health care system.

At the outset, let me commend President and Mrs. Clinton for their tireless efforts, both in developing the massive proposal and in focusing the Nation's and the Congress' attention on the need for health care reform.

The President is absolutely right when he says that the goal of health care reform should be to guarantee to every citizen universal access to high-quality, affordable, and comprehensive health care services. On this important issue and many others, there is consensus today where none existed before.

For these reasons, I have agreed to stand with the President as an original cosponsor of his bill. I, of course, still have my disagreements with the President on the means, and I have serious doubts about some of his objectives, which brings me to the subject of today's hearing.

I have very grave concerns with the President's proposal to enroll Federal employees and retirees in 1998 in the State regional health alliances and to abolish the Federal Employees Health Benefits Program, FEHBP.

FEHBP is a generally well-run program that serves nearly 9 million Federal employees, retirees, and dependents. It has been an important employee benefit for over 30 years. In recent years it has compiled an impressive record in controlling costs. And it is frequently cited by the administration and others as a model of managed competition.

I do not believe the Congress should abolish a program that not only works well, but works well for so many people, unless we make sure it's in the best interests of Federal employees and retirees.

To make this determination, the committee must fully understand the health policy rationale for that proposal. I expect our witnesses today will address that point.

The committee must know what effect the administration's proposal will have on the health benefits and out-of-pocket costs of FEHBP enrollees. Although the need for supplemental benefits is evident, the administration so far has not made a no-take-away guarantee to its employees and future retirees. Such a guarantee seems the right thing to do.

Finally, the decision to integrate the FEHBP into the new system will greatly hinge on the merits of the overall proposal. What's good for America will also be good for Federal employees.

As the President's proposal was being developed, we on this committee kept an open mind and will continue to do so until we have had ample opportunity to hear testimony and review the legislation. As I have said before, I want what is best for both our country and for Federal workers.

Are there any other opening statements? Mr. Myers.

Mr. MYERS. Well, thank you, Mr. Chairman. And I thank you and compliment you for this hearing.

All of us recognize that there have been and continue to be some problems on health care in this country. I don't think there's any question but that it needs some fixing.

But I'm concerned that we may be destroying some of the good programs that we have. At least some of the proposals being made by the President and others would destroy some of the good programs that now exist.

Now, in talking to a great many Federal employees, I haven't found too many who favor much change. What we want to do for our country, including our Federal employees and retirees, is make medical care, needed medical care, available, accessible at a cost they can afford, but, most importantly, we want to make sure it is available. As we look at some of the international programs in other countries, which are cheap, even free in some countries, is it available?

And this is, I think, the primary concern that we must all be concerned with, that we do continue to provide. And I think all Federal employees who are under the insurance programs, some are better than others, but there are a great many fine, very fine Federal programs that I hate to see destroyed because a few in the country don't have. I think we need to supplement, but let's don't destroy the good programs that we presently have.

So I compliment you for this, starting these hearings, which I'm sure between now and next year, when we finally hopefully come down with some proposal here on health care.

Of course, the Federal employees, the best place to start is OPM. So we thank you for coming today to give us your expert experience. Thank you.

Mr. CLAY. Are there any other opening statements? Mr. McCloskey.

Mr. MCCLOSKEY. Mr. Chairman, I thank you very much. I just ask that my opening statement be accepted for the record. My concerns are very similar to yours, and I appreciate you conducting the hearing.

[The prepared statement of Hon. Frank McCloskey follows:]

PREPARED STATEMENT OF HON. FRANK MCCLOSKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

The Federal Employees Health Benefits Program [FEHBP] has been recognized as one of the premier health care programs in the United States. FEHBP has been designed to maximize choices available to employees while comparatively minimizing the rate of cost increases. In fact, the President used it as the model for his managed competition plan. Given the general success of FEHBP, I wonder if we will be throwing the baby out with the bathwater, if we force Federal employees from a sound system into large regional health alliances. I have three broad concerns about the Clinton package for Federal employees: higher premiums with less coverage; the adequate coverage of temporary employees; and the treatment of Federal employees abroad.

Under the President's proposal all other major employers and companies including the U.S. Postal Service will be allowed to establish their own health care alliances. Furthermore, the Department of Veterans Affairs health care system as well as the Indian Health Service remain intact. Nonetheless, because of political considerations, the administration plans to eliminate FEHBP, and fold Federal employees and retirees into regional health alliances by 1998.

One of my major concerns with the Clinton health care plan is whether Federal employees will pay higher premiums for less coverage. Although, the Government will contribute more for Federal employees' benefits, 80 percent instead of the current contribution of 72 percent, it is unclear whether that will result in lower premiums for Federal employees. I hope that my good friend, Jim King, will be able to address this issue in his testimony this afternoon.

Under the President's proposal, dental and prescription eyeglass care will be phased in and, initially, only available to children. Presently most Federal employees, depending on the plan they elect, have some type of dental and vision care. Will Federal employees lose their benefits if the Clinton plan is enacted?

Another major concern of mine is the treatment of temporary Federal employees under the Clinton health care plan. I found the President's proposal to be ambiguous in its discussion of coverage for temporary employees. It did not explicitly include Federal temporary workers nor did it specifically exclude them from coverage. In OPM's testimony from a hearing I conducted last June on the use of temporary employees in the Federal Government, Mr. King said that, "We understand that both coverage of temporary employees and funding of that coverage will be addressed in a comprehensive way as part of the President's health care proposal." Unfortunately, I do not find that to be the case.

I hope at today's hearing OPM will pledge that all Federal employees whether they be temporary, term, or full-time employees receive health care coverage with the Government contributing 80 percent of the premium. I introduced legislation in the last two Congresses, sponsored by many members of this committee, to provide access to health care benefits for temporary employees, and it is extremely important to myself and to the members of this committee that health care for temporary workers be addressed.

In addition, as chairman of the subcommittee with jurisdiction over Foreign Service personnel, I also have concerns about the treatment of Federal employees abroad. I wonder whether coverage abroad substantially similar to what is offered by FEHBP or by the health care alliances is feasible. Furthermore, at what cost will OPM be able to acquire insurance for Federal employees overseas?

I applaud the President for making universal health care coverage a priority and I hope that with the help of my colleagues in Congress that we make this a reality. I want to commend Chairman Clay for convening this first in a series of hearings on the President's health care reform package so quickly.

I also want to thank my good friend, Jim King, Director of OPM and Ms. Judith Feder for taking time from their busy schedules to appear before the committee this afternoon.

Mr. CLAY. Without objection, the statement will be included. And without objection, all statements will be included.

Mr. SAWYER. Ms. Norton, do you have a statement?

Ms. NORTON. I ask unanimous consent that it be included in the record.

[The prepared statement of Hon. Eleanor Holmes Norton follows:]

PREPARED STATEMENT OF HON. ELEANOR HOLMES NORTON, A REPRESENTATIVE IN CONGRESS FROM THE DISTRICT OF COLUMBIA

I join the Members of this Committee in commending the Administration's effort to reform our Nation's health care system. The Health Security Act of 1993 reflects the intelligence and dedication with which a new and energetic Administration has approached what is now one of the most significant issues in the minds of the American public. As health care reform is likely to define the Administration itself, so also is the Committee's important piece of the proposal likely to be among our most important work this session.

We know for sure that Federal employees value their health care above all other benefits. During budget reconciliation, Federal employees were asked to accept enormous sacrifices to enable the Administration to achieve its deficit reduction goals. Federal employees stepped up to the plate to shoulder more than their share for deficit reduction, but they emphasized that maintaining the level of their health care coverage was their top priority.

The Federal government has long understood the importance of health care as a workplace benefit, and in many ways, has been a model employer in providing health benefits. For this reason, I am concerned that the initial Administration's proposal limits hospitalization coverage in fee-for-service plans to 80 percent. Under the current FEHBP, 100 percent of this cost is typically covered. I commend the Office of Personnel Management (OPM) for what I understand may be a supplemental insurance proposal to bridge this gap. However, we need to know more about the criteria OPM will use to determine the scope of the supplemental plans, who will be eligible to receives supplemental coverage, and, above all, the cost of these supplemental plans.

I would also mention that I am especially concerned about the impact of the President's plan on the District of Columbia, a jurisdiction with an unusually large number of Federal employees. The District's unique position as a city without a state structure could make it difficult to establish an alliance with a diverse enough pool to allow affordable rates.

I welcome today's witnesses and look forward to hearing your testimony and answers to our questions.

Mr. CLAY. Mr. Wynn. Mr. Hastings.

Our witness today is Mr. Jim King, Director of the Office of Personnel Management. And he's accompanied by Dr. Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services.

Without objection, Mr. King, your entire statement will be entered in the record, and you may proceed as you see fit.

STATEMENT OF JAMES B. KING, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, WASHINGTON, DC; ACCOMPANIED BY DR. JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. KING. Thank you for inviting us to discuss the President's health security proposal and its likely effect on Federal civilian employees and retirees and the benefits they currently enjoy under the Federal Employees Health Benefits Program, FEHBP.

And I'll refer to the FEHBP from time to time as "our program" because it's a program I use and so many of us here in Washington use. If you'll bear with me, let the record reflect "program" would mean "FEHBP."

Accompanying me, as you suggested, Mr. Chairman, is Dr. Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, who will respond to any questions concerning the health security plan in general. I don't pretend to be an expert on that at all.

The Federal Employees Health Benefits Program, established in 1960, as you, Mr. Chairman, and the committee are aware, is the country's largest employer-based health insurance program.

Under our program, the Office of Personnel Management, acting on behalf of 9 million-plus people, that is, employees, retirees, and eligible dependents, contracts annually with about 300 participating insurance plans and health maintenance organizations, [HMOs] and also provides comparative information to assist individuals in making informed choices among the plans available in each area.

The Government contribution formula, which is based on the average premium charges under a set of plans designated by law, covers about 72 percent of the cost of enrollment on average.

Compared to insurance programs available to many other Americans today, ours is a superior program because it exhibits many of the principles the President has identified as the foundation of this Health Security Act.

The Federal employee program operates much like the regional health alliances the President is proposing. So Federal employees should not experience any significant change when they move into the new system.

Those features that have made our employee insurance program such a good program are preserved and enhanced under the Health Security Act, and other desirable features have been added.

After 1997, all Federal employees and non-Medicare-eligible retirees, like other members of their communities, will choose health insurance coverage from among health plans offered by a national health alliance or a State single-payer plan.

Federal employees, like other Americans, will no longer need to worry about becoming uninsured because of changes in employment or family status. Simple, easy-to-understand, and up-to-date information about quality and price will help them choose among plans.

And the systems for receiving informational materials, designating their enrollment choices, and paying their premiums will be so similar to the systems in place now that the transition should be almost with no real change to the typical Federal employee.

Let me give you some examples of how our employee program and the proposed health security system compare. The Health Security Act is based on the same principle of broad consumer choice of plans embodied in the present Federal program.

The benefits package provided in the act shares features of some of the best plans in the Federal program. Our employee insurance program prohibits waiting periods or exclusions for preexisting conditions in its contracts. The Health Security Act preserves the guarantee that no one can be denied coverage because of a preexisting medical condition or lose coverage because of a particular illness.

In addition to preserving the strengths of the Federal employee program, the Health Security Act addresses problems our program has not been able to solve. Our cost experience has been far better than that for the insurance market in general in the health care field, in part because we have encouraged the use of efficient delivery systems, such as health maintenance organizations and networks of doctors and hospitals. But our cost increases continue to

run above the economy's general rate of inflation. This will, it appears, always be the case without the kinds of changes offered in the President's proposal.

To reduce costs we must achieve the goals of the Health Security Act: simplifying this Nation's health care bureaucracy, controlling inefficient use of our resources, and ensuring the opportunity for every American to participate.

On that last point, ensuring that all can participate, we need to acknowledge that, despite the access to coverage afforded permanent Federal employees through our program, some employees eligible for coverage decline to participate because of the cost; and temporary employees are often excluded or those who work for long periods are eligible only if they pay 100 percent of the cost of the insurance. The Health Security Act would ensure affordable health insurance coverage for these Federal employees for the first time.

The Health Security Act would use progressive discounts to ensure that lower income workers who currently cannot afford health benefits would not pay more than a fixed percentage of their household income for health insurance premiums.

While comprehensive benefits will continue to be offered under the act, the slower rate of growth of health care spending will moderate future health care premium increases.

Moreover, the Government's contribution for employee and non–Medicare-eligible retirees will be 80 percent of the average premium, instead of the current 72-percent average contribution under the Federal employee program.

For all who are current Federal retirees on the day preceding repeal of the Federal employee insurance program, the act would require the Office of Personnel Management to develop plans with appropriate Government contribution to preserve the level of benefits such individuals previously had available under the employee program or under combined Medicare and Federal employee health benefits coverage.

The act would further permit OPM to offer one or more supplemental health plans to current employees and future retirees, with and without Medicare eligibility, on the same basis.

Both current and future Medicare-eligible retirees would have the choice of receiving benefits, either through wraparound policies or through managed care plans with Medicare risk contracts. These provisions for supplemental insurance plans are intended to ensure that the Government remains a competitive employer, a critical issue for us.

In conclusion, I wish to convey a very special thanks to the committee, under your leadership, Mr. Chairman, for the strong interest you have taken in how the Health Security Act will affect Federal employees and retirees. Your close attention to every aspect of the proposed legislation is very much appreciated.

I am confident that the enrollees now in the Federal Employees Health Benefits Program will fare well under the Health Security Act, and I look forward to continuing to work with you and the committee to achieve early enactment.

Again, thank you. I know that there will be questions, and we will make every effort to respond to them, Mr. Chairman.

[The prepared statement of Mr. King follows:]

PREPARED STATEMENT OF JAMES B. KING, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

Mr. Chairman and members of the committee: Thank you for inviting me to discuss the President's health security proposal and its likely effect on Federal civilian employees and retirees and on the benefits they currently enjoy under the Federal Employees Health Benefits Program [FEHBP]. Accompanying me is Dr. Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, who will respond to any questions concerning the health security plan in general.

The FEHBP, established in 1960, is the country's largest employer-based health insurance program. Under the program, the Office of Personnel Management, acting on behalf of 9 million plus insureds—employees, retirees, and eligible dependents—contracts annually with about 300 participating insurance plans and health maintenance organizations [HMO's] and provides comparative information to assist individuals in making informed choices among the plans available in each area. The Government contribution formula, which is based on the average premium charges under a set of plans designated by law, covers 72 percent of the cost of enrollment on average.

Compared to insurance programs available to many other Americans today, the FEHBP is a superior program because it exhibits many of the principles the President has identified as the foundation of the Health Security Act. The FEHBP operates much like the regional health alliances the President is proposing, so Federal employees should not experience a significant change when they move into the new system. Those features that have made the FEHBP such a good program are preserved and enhanced under the Health Security Act, and other desirable features have been added.

After 1997, all Federal employees and non-Medicare eligible retirees, like other members of their communities, will choose health insurance coverage from among health plans offered by a regional health alliance or State single-payer plan. Federal employees, like other Americans, will no longer need to worry about becoming uninsured because of changes in employment or family status. Simple, easy-to-understand, and up-to-date information about quality and price will help them choose among plans. And the system for receiving information materials, designating their enrollment choices, and paying their premiums will be so similar to the systems in place now that the transition should be almost with no disruption to the typical Federal employee.

Let me give you some examples of how the FEHBP and the proposed health security system compare. The Health Security Act is based on the same principle of broad consumer choice of plans embodied in the FEHBP. The benefits package provided in the act shares features of some of the best plans in the FEHBP. The FEHBP prohibits periods or exclusions for preexisting conditions in its contracts. The Health Security Act preserves the guarantee that no one can be denied coverage because of a preexisting medical condition or lose coverage because of a particular illness.

In addition to preserving the strengths of the FEHBP, the Health Security Act addresses problems the FEHBP has not been able to solve. Our cost experience has been far better than for the insurance market generally, in part because we have encouraged the use of efficient delivery systems such as HMO's and networks of doctors and hospitals. But our cost increases continue to run above the economy's general rate of inflation. This will, it appears, always be the case without the kinds of changes offered in the President's proposal. To reduce costs we must achieve the goals of the Health Security Act: simplifying this Nation's health care bureaucracy, controlling inefficient use of resources, and ensuring the opportunity for every American to participate.

On the last point—ensuring that all can participate—we need to acknowledge that, despite the access to coverage afforded permanent Federal employees through the FEHBP, some employees eligible for coverage decline to participate because of the cost. And temporary employees, even those who work for long periods, are eligible only if they pay 100 percent of the cost of insurance. The Health Security Act would ensure affordable health insurance coverage for these Federal employees for the first time. The Health Security Act would use progressive discounts to ensure that lower income workers who currently cannot afford health benefits, would not pay more than a fixed percentage of their household income for health insurance premiums.

While comprehensive benefits will continue to be offered under the act, the slower rate of growth of health care spending will moderate future health care premium increases. Moreover, the Government's contribution for employee and non-Medicare-

eligible retirees will be 80 percent of the average premium, instead of the current 72-percent average contribution under the FEHBP.

For all who are current Federal retirees on the day preceding repeal of the FEHBP, the act would require the Office of Personnel Management to develop plans, with appropriate Government contribution, to preserve the level of benefits such individuals previously had available under FEHBP or under combined Medicare and FEHBP coverage. The act would further permit OPM to offer one or more supplemental health plans to current employees and future retirees (with and without Medicare eligibility) on the same basis. Both current and future Medicare eligible retirees would have the choice of receiving benefits either through wrap-around policies or through managed care plans with Medicare risk contracts. These provisions for supplemental insurance plans are intended to ensure that the Government remains a competitive employer.

In concluding, I wish to convey special thanks to the committee under your leadership, Mr. Chairman, for the strong interest you have taken in how the Health Security Act will affect Federal employees and retirees. Your close attention to every aspect of the proposed legislation is very much appreciated.

I am confident that FEHBP enrollees will fare well under the Health Security Act, and I look forward to continuing to work with you to achieve early enactment.

Thank you again. I would be glad to respond to any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. WILLIAM L. CLAY TO JAMES B. KING

Question 1a. The FEHBP is often cited as one of the models for the administration's proposal for regional health alliances. Further, many congressional and private experts have commented that with some minor changes in the program, the FEHBP could rather quickly and easily become a working prototype of managed competition. Yet, the administration chose to propose dismantling the FEHBP. What other options did the administration consider with regard to the operation of the FEHBP? What were the reasons that each option was rejected?

Answer. The Health Reform Task Force Working Group that considered integration of the FEHBP into the national health reform proposal developed policy papers that presented a full range of options from retaining the program as is to abolishing the program. Credible pros and cons were provided for each option.

Question 1b. What are the health policy reasons for dismantling the FEHBP and enrolling Federal employees in the State regional alliances?

Answer. The Health Security Act offers all Americans, including Federal employees, a program based on six underlying principles that address the major problems facing our national health care system. Although Federal enrollees are less vulnerable than other Americans in some areas, overall, the new system will be better for Federal enrollees and better for the country than what we have today.

The reform would extend the security of affordable health insurance to all Federal employees by providing premium discounts for lower-income workers and equal access to employer-supported health insurance for permanent and temporary workers. Furthermore, Federal employees and their families, like other Americans, would no longer need to fear becoming uninsured since alliance eligibility would not terminate due to changes in employment or family status.

Federal enrollees would continue to enjoy essentially the same comprehensive health care benefits the FEHB Program now offers, but the Government premium contribution would increase to 80 percent of the average premium, compared to the current 72 percent FEHB contribution.

Standardization of benefits, cost-sharing arrangements, and consumer information requirements for all regional alliance health plans would make plan comparison and informed choice easier. Individual health security cards for accessing services and uniform billing and claims processing systems would result in an administratively simpler and more efficient system for enrollees to deal with.

Question 2a. Will the dismantling of the FEHBP and the participation of Federal employees in regional health alliances allow the Federal Government to maintain better control over the cost and quality of health benefits purchased for its employees?

Answer. The HSA would result in lower future premium increases for regional alliance health plans. OPM's long-term success with FEHBP cost-containment is less dramatic than the modest 1994 average premium increase would indicate. Over the last 10 years, annual charges in the FEHBP average premium have fluctuated from an annual decrease of 11 percent in 1986 to an increase of 25 percent in 1988. On average, increases have been equivalent to about 11 percent over that period; while

this is about 3 percentage points below the national trend in health insurance inflation, an 11 percent rate of increase is clearly unsustainable.

Question 2b. Will the dismantling of the FEHBP and the participation of Federal employees in regional health alliances improve the ability of the Federal Government to recruit and retain qualified workers in competition with both small and large employers?

Answer. The HSA provides sufficient flexibility to the Government as an employer to remain competitive. But ultimately, because Federal employees will be treated like all other Americans, health insurance coverage will no longer be a major issue in recruitment and retention of workers.

Question 3a. Under the bill, the medical programs operated by the Veterans Affairs Department and the Defense Department would not be completely dismantled, and participants would not be enrolled in the regional health alliances in the same manner that Federal workers would be. What is the health policy basis for this difference in treatment of the FEHBP and these other Federal medical programs?

Answer. The Federal programs that are not being integrated into the national system are in whole or in part service delivery programs that serve special populations, often with special needs. They are in a position to compete as health plans for their eligible populations. Our program is an employer-provided insurance program that provides no direct services. Our role can readily be handled by the regional alliances.

Question 3b. How does the FEHBP's experience over the last 5 years in controlling costs compared with that of the medical programs operated by the VA Department and DOD?

Answer. FEHBP premium increases are the result of multiple factors including but not limited to cost control efforts. The chart that follows shows the FEHB weighted average monthly premium and percent increase from the prior year for the years 1990 through 1994. Since we do not have data for the other programs we cannot make a comparison.

FEHB PREMIUM INCREASES, 1990–94

	1989	1990	1991	1992	1993	1994
Weighted average monthly premium	235.86	256.46	268.48	288.25	312.2	323.18
Percent increase from prior year	.....	8.73	4.69	7.36	8.32	3.51

Question 4a. Under H.R. 3600, The United States Postal Service is the only Federal agency treated in the same manner that other large employers are treated. What are the health policy reasons for this different treatment?

Answer. The are no immediately obvious health policy reasons for either including or excluding postal employees from the regional alliances.

Question 4b. What is the impact of H.R. 3600 on the Postal Service's early retireees? What is the impact on the Postal Service's other retirees?

Answer. For Postal Service early retirees—that is, retirees between the ages of 55 and 65, who have performed employment that entitles them to Medicare Part A hospital insurance at age 65—the Government would assume liability for repayment of the alliance credit covering 80 percent of the average alliance premium, in accordance with section 6114. If such individual meets the early retiree requirements as of October 1, 1993, the Postal Service would be responsible for paying at least 20 percent of the average alliance premium, under section 1608. Retirees below the age of 55, early retirees who will not be eligible for Medicare Part A at age 65, and any other annuitants as defined under the FEHB law (as last in effect), would be eligible for a Government-funded 80 percent alliance premium credit authorized by section 8203(c)(1)(B); these annuitants would pay the remainder of the applicable premium.

Question 4c. If the Postal Service decides to operate a corporate alliance, what supplemental health benefits will its Medicare-eligible retirees be entitled to under the proposal?

Answer. The Health Security Act [section 8203(e)] would allow any individual who, as of December 31, 1997, is currently eligible for Medicare Part A benefits and, but for subtitle C of title VIII of the HSA, would be eligible for a Government FEHB contribution, to enroll in the Medicare supplemental plan(s) that OPM must develop to reflect previous FEHB coverage. However, the HSA does not specify mechanisms for how current Medicare-eligible Postal Service retirees would be covered. If they continue to be provided coverage administered through OPM, then a Postal Service funding mechanism would be needed such as is currently provided in chapter 89 of

title 5 of the United States Code. Future Medicare-eligible Postal Service retirees would be covered in a manner to be determined by the Postal Service.

Question 4d. Is the administration aware of any factors peculiar to the Postal Service—structural, legal, or otherwise—that would make it difficult for the Postal Service to operate a corporate alliance?

Answer. The Postal Service is currently conducting an analysis of the factors that might affect the choice between corporate and regional alliances. On February 8, 1994, Joseph J. Mahon, Jr., Vice President of Labor Relations for the Postal Service, testified before the House Post Office and Civil Service Committee on their ongoing analysis. Mr. Mahon highlighted a number of complicated factors in assessing the choice, including the fact that the Postal Service currently does not have in place resources or infrastructure to administer its own health benefits program. We defer to the Postal Service and await the outcome of its analysis.

Question 5a. Please compare the actuarial value of the health benefits in H.R. 3600's High Cost-Sharing plan with the actuarial value of the non-PPO benefits offered in 1994 by the five largest open fee-for-service plans and the Beneficial Association of Congressional Employees plan.

Answer.

Actuarial value of high cost-sharing plan as compared to non-PPO benefits in selected fee-for-service plans

Proposal—High Cost-sharing	1.00
BC/BS—Standard	1.02
Mail Handlers—High	1.07
APWU	1.04
GEHA	1.06
NALC	1.07
BACE	1.07

Question 5b. Please compare the actuarial value of the low cost-sharing plan in H.R. 3600 with the actuarial value of the benefits offered in 1994 by the five health maintenance organizations with the largest FEHBP enrollment.

Answer.

Actuarial value of low cost-sharing plan as compared to selected HMO's

Proposal—Low Cost-Sharing	1.00
Kaiser—Northern California	1.01
Kaiser—Southern California	1.00
Kaiser—D.C	1.07
GHI, New York	1.01
Health Plus D.C	.97

Question 5c. Please compare the actuarial value of the health benefits of the combined plan in H.R. 3600 with the actuarial value of the PPO benefits offered in 1994 by the five largest open fee-for-service plans and the BACE plan.

Answer.

*Actuarial value of combined plan proposal as compared to combined plan (PPO and non-PPO) of five largest plans**

Combined Plan	1.00
BC/BS Standard PPO	1.01
Mail Handlers High PPO	1.01
GEHA PPO	.98
APWU PPO	.98
NALC PPO	.98
BACE PPO	1.06

* For the Combined Plan, we made an assumption that 50 percent of the people would be in the Low Cost-Sharing Plan and 50 percent would be in the High-Cost Sharing Plan. For other Fee-For-Service plans we assumed 50 percent would be in the PPO and 50 percent would be in the non-PPOs.

Question 5d. Please provide the committee with details concerning the actuarial process and methodology used in making the comparisons described in subparagraphs (A), (B), and (C). Please include your assumptions, if any, in respect to the anticipated utilization split between network and non-network services in the case of subparagraph (C)

Answer. The actuarial values were determined for major indemnity and HMO plans using an enhanced version of the methodology recommended by the American Academy of Actuaries. Values of services for a standard population were determined

for inpatient care, outpatient care, mental and nervous, drugs, dental, and vision and hearing. The basic methodology sets values for the total of covered services in each category controlled to actual experience, and uses FEHBP developed continuance functions to determine the portion actually reimbursed by each plan. We provided a detailed description of this methodology to the consultants who worked on the Committee's report on the FEHBP.

Question 6. Under H.R. 3600, what coverage does a Federal worker or retiree residing overseas have if he or she relocates to a State after January 1, 1998 (after every State alliance is operating and the FEHBP has been dismantled)? What coverage do Federal workers have if they are transferred overseas by their employing agencies after 1998?

Answer. A Federal worker or retiree who relocates to a State will be treated like any other Federal worker or retiree. If they are not Medicare eligibles, they will enroll in a regional alliance and they will receive the same Government contribution to health premiums as other similarly-situated Federal enrollees. Workers transferred overseas will be covered by the overseas plan administered by OPM.

Question 7a. Please provide the committee with the administration's estimates of the average premium costs for H.R. 3600's standard benefit package.

Answer. See attachment 1.

Question 7b. Please provide the committee with estimates of the average premium costs of H.R. 3600's high cost-sharing, low cost-sharing, and combined plans.

Answer. We have not done this type of estimate. Our premium estimate is a national average premium for all types of plans.

Question 7c. Please provide the committee with the explanation of the assumptions and methodology used in developing the estimates requested under subparagraphs (A) and (B).

Answer. See attachment 2.

Question 7d. In addition, please provide the committee with an estimate of the cost of the standard benefit package on a per-employee basis in a manner comparable to the basis employed in the recent study by the Bureau of Labor Statistics (at the request of the Health Care Financing Administration).

Answer. See attachment 3.

Question 8a. The administration claims that the Federal Government will save $13.2 billion during the period 1995 through 2000 as a result of the proposed changes in the FEHBP. At the same time, the Government's share of premium costs will rise from 72 percent to 80 percent. And the Government will be responsible for paying premiums for all of its employees (including, for example, those who are now insured under their spouses's plan and those who are uninsured). How did the administration arrive at this estimate of program savings? Please include a breakdown of the sources of any cost savings.

Answer. Savings for H.R. 3600 were re-estimated for the President's FY 1995 Budget to coincide with updated assumptions, including updates to the baseline for technical and economic changes. The revised estimate of $8.2 billion in savings can be found on page 189 of the President's FY 1995 Budget.

There are a number of factors contributing to the savings projected for the FEHBP population. As Federal employees and annuitants move into the national health program, some will fall into insured categories that require financing from sources other than, or in addition to, existing Federal accounts. The largest part of these savings is associated with changes in the financing of insurance for retired Federal employees. The following provides a general break out of the $8.2 billion savings assigned to the FEHB Program.

Under the Health Security Act, the Government will provide an "early retiree" discount to finance 80 percent of health plan premiums for all retired persons who are between the ages of 55–64 and have performed employment which qualifies them for Medicare hospital benefits at age 65. So, for civil service annuitants between the ages of 55–64 financing for 80 percent of their insurance premium will be provided through a "Government discount" account as opposed to the Government payment account administered by OPM. However, early retirees who meet the criteria in section 1608 will also receive an employer contribution equal to the remaining 20 percent of their alliance premium. These net savings total $2.8 billion.

Further, OPM will develop and administer a Medigap plan for Medicare-covered annuitants. Savings will occur since the Government share of the proposed Medigap plan will be less expensive than the current FEHBP premiums. Net savings to the Government equal $3.5 billion.

The health reform program will result in significant savings in health insurance costs for active Federal employees, as well, due to slower increases in premium rates and premium contributions by spouses' employers. Such savings will more than offset new Government costs resulting from the requirement to pay contributions on

behalf of workers and annuitants not currently enrolled in FEHB, including Federal workers who are either not eligible for FEHB coverage or have not elected to enroll, and Federal annuitants without qualifying employment for Medicare entitlement, who now are either uninsured or covered under a spouse's insurance. In addition, there would be a slight cost to OPM for the late enrollment penalty for annuitants who want to assume Medicare Part B coverage once FEHBP is terminated. The total cost is $300 million. Net savings: $1.9 billion.

Question 8b. Does the estimate take into account the cost of supplemental benefits for both employees and retirees?

Answer. The savings estimates do not account for the cost of supplemental benefits for employees or non-Medicare annuitants. However, the estimates do account for an employer contribution for coverage of Medicare annuitants under a Medigap plan which will be developed and maintained by OPM beginning in FY 1998.

Question 8c. Does the estimate take into account the coverage of Federal workers and retirees residing abroad?

Answer. The savings estimates assume overseas employees and annuitants currently enrolled in the FEHB will continue to receive coverage.

Question 8d. Does the estimate take into account the cost of early retirees?

Answer. The estimates assume that early retirees (ages 55–64) will have an employer contribution equal to 20% of the alliance premium as opposed to the 80% assumed for all other alliance annuitants.

Question 8e. Does the estimate take into account the FEHB fund reserves?

Answer. The estimates do not reflect the disposition of the FEHB fund reserves.

Question 9a. Under H.R. 3600, FEHBP annuitants who qualify as "Early Retirees" would have the 80-percent employer portion of the premium paid by the Federal Government and the annuitants' 20-percent portion paid for by OPM as the employer. Please advise as to the specific provision or provisions of H.R. 3600 that would authorize the Federal Government to pay the 80 percent.

Answer. Sections 6114 and 9102 of H.R. 3600 provide the authority for the Government to repay the 80 percent alliance credit amount on behalf of all Federal annuitants who qualify as "early retirees".

Question 9b. Please confirm that section 1608 of H.R. 3600 sets forth the obligation of OPM to pay the 20-percent employee portion for any FEHBP annuitant who qualifies thereunder.

Answer. Section 1608 requires certain employers, including the Federal Government, to make an employer contribution for the 20 percent family share of health plan premiums for Federal annuitants who, as of October 1, 1993, would qualify as "early retirees" under section 6114. ("Employer" is defined in section 1901 of the HSA to mean the same as in 26 U.S.C. 3121.) Subtitle C of Title VIII of the bill needs to be revised to expressly authorize appropriations for Government contributions required by section 1608.

Question 9c. Please confirm that section 8203(c)(1)(B)—Lines 13 through 19 on page 1237—sets forth the obligation of OPM, as employer, to pay the 20-percent employee portion on behalf of FEHBP annuitants who are under age 55.

Answer. Section 8203(c)(1)(B) authorizes the Government to fund the 80 percent alliance health plan premium credit (not the 20 percent family share of premium) on behalf of any individual who qualifies as an annuitant for purposes of the FEHB law as last in effect and is not an eligible "early retiree" for purposes of section 6114. Notwithstanding the catchline, this provision is not limited only to those Federal annuitants who are under age 55.

Question 9d. Please advise as to the specific provision of H.R. 3600 which explains who pays the 80-percent portion of premium for annuitants who do not qualify as "early retirees."

Answer. Notwithstanding the catchline, section 8203(c)(1)(B) explains who pays the 80 percent alliance credit amount for any annuitant who is not an early retiree for purposes of section 6114.

Question 10a. H.R. 3600 requires that all existing contracts between OPM and FEHBP plans be terminated on December 31, 1997. Nevertheless, enrollees would have two years from the date of a service to file claims with their former FEHBP plans. How would the "claims run-out" procedure work under H.R. 3600? What would happen if a FEHBP plan stopped doing business before the end of the two-year period?

Answer. Section 8205 of H.R. 3600 provides that the Employees Health Benefits Fund shall be maintained and remain available for as long as OPM considers necessary in order to satisfy outstanding claims. Therefore, the "claims run-out" procedure would be no different than it is now. If a plan stopped doing business before the end of the two year period, the reserves would still be used to pay accrued claims. If necessary, alternate sources of claims processing would be acquired.

Question 10b. In the shut-down of existing plans, what measures does OPM anticipate taking to achieve an orderly transition and mitigate any severe economic hardship to (a) FEHBP plans and their employees, and (b) FEHBP enrollees of plans that terminate operations prior to December 31, 1997?

Answer. Once H.R. 3600 is enacted, OPM will begin transition planning. OPM will provide guidance and assistance to agencies, carriers, and regional alliances to achieve an orderly transition. Contract termination procedures and financial arrangements would be in accordance with the provisions of the Federal Acquisition Regulation. Current FEHBP plans, like other insurance plans, will be eligible to participate in the regional alliances. FEHBP enrollees of plans that terminate operations prior to December 31, 1997, will not experience any economic hardship. They will be eligible, as they are now, to enroll immediately in another FEHBP plan, and if they have outstanding claims, those claims will be paid just as they are now.

Question 11a. H.R. 3600 provides that OPM shall offer supplemental plans to all Federal employees, both current and future annuitants and current Medicare-eligible individuals, but provides for Government contributions toward the costs of the supplemental benefits only in respect to current annuitants and Medicare-eligible individuals. Please provide the committee with a detailed explanation of and the policy underlying the provisions found on page 1238, lines 4 through 21, and page 1241, lines 6 through 18.

Answer. The policy underlying the provisions cited was to ensure (1) that the health insurance coverage of current retirees would not be adversely affected under the Health Security Act; and (2) that in the future the Federal Government as an employer would have the same options as any other employer with regard to health insurance coverage for its employees and retirees. While the Act does not mandate a Government contribution, it does not preclude one. The Government would be free to decide on a benefits policy that would enable it to compete with other employers to meet its workforce needs.

Question 11b. Please explain whether OPM would have the legal authority to pay a Government contribution toward the purchase of supplemental benefits for employees and future annuitants.

Answer. The only circumstance in which the HSA expressly prohibits a Government contribution toward supplemental benefits for Federal beneficiaries is in subsection 8203(d) concerning individuals to whom the FEHB law now extends coverage without Government contribution. However, H.R. 3600 makes no provision for appropriations authority to fund discretionary Government contributions.

Question 12. Under H.R. 3600, Lower paid workers will be eligible for certain subsidies in order to purchase insurance. Are Federal employees eligible for the same subsidies?

Answer. The subsidies (or discounts) provided for lower-paid workers will apply to Federal employees after January 1, 1998, when they are integrated into the regional alliances. This is an enormous advantage for those employees who are now eligible but cannot afford to enroll in the FEHBP.

Question 13. Please provide the committee with the administration's estimates for the FEHBP's total program costs and employer's costs for the following years: fiscal year 1993 through fiscal year 1997, and please provide the committee with the administration's estimates for fiscal year 1998 through fiscal year 2000 of the employer's costs of providing health benefits to Federal workers and retirees under the new system.

Answer.

HEALTH BENEFITS FOR FEDERAL WORKERS AND RETIREES—FISCAL YEAR DATA

[In billions]

	Current system					Reform system		
	1993	1994	1995	1996	1997	1998	1999	2000
Government cost	8.8	8.8	9.6	10.4	11.4	10.1	9.5	9.9
FEHB program cost	11.8	12.5	13.5	14.8	16.2	.....	.....	.....

Notes.—(1) The above estimates exclude costs associated with the Postal Service. (2) Estimates assume that the FEHB contracts terminate on 12/31/97. The FY 1998 cost assumes FEHB premiums will be in effect during the first quarter of the fiscal year and alliance premiums applied during the remaining nine months.

Question 14a. Citing specific sections of H.R. 3600, please explain how temporary Federal workers would be treated under the bill.

Answer. Section 8203(a) of H.R. 3600 provides that the Act will apply after termination of the FEHBP for persons who both are eligible individuals under the HSA and, but for repeal of the FEHB law under the HSA, would be eligible to enroll in

an FEHB plan. Section 1001(c) defines eligible individuals for HSA purposes to include all legal residents of the United States.

Accordingly, temporary Federal employees who are ineligible for FEHBP or Medicare coverage would be required, under section 1002, to enroll in an applicable HSA plan as soon as this becomes available on or after January 1, 1996 [see section 1511(a)(3)] and they would be entitled to applicable employer contributions as required by section 6121.

Question 14b. Are there other Federal employees who currently are not eligible to enroll in the FEHBP pursuant to chapter 89 of title 5, U.S. Code, and who would still be ineligible to enroll in a regional alliance under H.R. 3600?

Answer. The FEHB law [5 U.S.C. 8901(1)(ii)] excludes individuals who are neither citizens nor nationals of the United States and whose permanent duty station is outside the United States (except for certain employees in the Panama Canal Zone). All such individuals are excluded under section 1001(c) of the HSA.

Question 15a. How does H.R. 3600 treat the following employees: employees who are neither citizens nor nationals whose permanent duty station, as of September 30, 1979, was the Panama Canal area and are currently enrolled in the FEHBP? If they are not eligible to participate in the regional alliances what will happen to them after 1998?

Answer. The people covered under the FEHBP Panama Canal Plan are a mixed group. Employees have to live in the Panama Canal Area to enroll in the plan, annuitants do not. About 12,000 Plan-covered annuitants live in Panama; about 95 percent of them are foreign nationals. By Treaty, the Panama Canal Commission will cease to exist on December 31, 1999. At that time, virtually all Federal facilities will close. Many of the 5,000+ active employee Plan members will retire. The total number of annuitants living in Panama will grow substantially when the Commission ends.

After 1979, only U.S. citizens could enroll in the plan; however, those foreign nationals who were enrolled before 1979 were allowed to continue their enrollment.

We don't intend that anyone covered under the current program will lose coverage under the Health Security Act. However, they do not meet the current definition of eligibles under the Act.

Question 15b. Individuals covered under the Government Employee Health Association Plan (Code 42)?

Answer. Those employees would be eligible for coverage under a regional alliance if they are employed in the United States. If they are employed overseas, OPM will continue to offer them a plan under the overseas program. Arrangements similar to those now in effect could be continued.

Question 15c. Employees at the six Federal agencies that offer their own health plans and the TVA?

Answer. Those employees would be eligible for coverage under their regional alliances like everyone else.

Question 16a. Currently, FEHBP enrollees pay a portion of a national premium. Under H.R. 3600, premiums would be established on a regional basis, meaning that many Federal workers nationwide would see a wide variation in the premiums that they pay for the same benefits. How does the administration propose to deal with the wide variation in premiums?

Answer. The Health Security Act addresses regional cost variations in the following ways. In the determination of alliance per capita premium targets, the National Health Board must consider information on variations in premiums across States. It is the alliance per capita premium target—not the national target—that will be used in controlling the rates of increases in premiums. Also, the Board is required to establish an advisory commission on regional variations in health expenditures which will study methods of eliminating variations in regional alliance per capita premium targets due to variations in practice patterns (not due to other factors, such as input prices). No later than July 1, 1995, the Board must submit recommendations on how to eliminate such variations before 2002.

Question 16b. How will the regional alliance risk pools compare with the FEHBP risk pool in terms of demographic characteristics, health status, and income? Please provide the committee with any data that the administration has on the risk pools of regional alliance areas.

Answer. Since the HSA provides great flexibility to individual States with regard to establishing health plan alliance boundaries, we cannot answer this question at this time.

Question 17a. On November 22, 1993, OMB Deputy Director Alice Rivlin testified before the Subcommittee on Health and Environment that "FEHB will pay lower premiums for many of its workers compared to today." Please provide the committee with an explanation of this statement and all of the data supporting it.

Answer. In addition to preserving the strengths of the FEHBP, the Health Security Act addresses problems the FEHBP has not been able to solve. Our cost experience has been far better than for the insurance market generally, in part because we have encouraged the use of efficient delivery systems such as HMOs and networks of doctors and hospitals. But our cost increases continue to run above the economy's general rate of inflation. This will, it appears, always be the case without the kinds of changes offered in the President's proposal. When we achieve the goals of the Health Security Act, simplifying this nation's health care bureaucracy, controlling inefficient use of resources, and ensuring the opportunity for every American to participate, costs certainly will be reduced for many workers.

Question 17b. Please provide data showing how many Federal workers and retirees will be paying lower premiums compared to today?

Answer. Since H.R. 3600 gives the States significant latitude in terms of how they set up their programs, we have no data at this time on which to base an estimate of premium differentials for Federal enrollees.

Question 17c. Please provide data showing how many Federal employees and retirees would be paying higher premiums?

Answer. Since H.R. 3600 gives the States significant latitude in terms of how they set up their programs, we have no data at this time on which to base an estimate of premium differentials for Federal enrollees.

Question 18a. Please provide an explanation to the committee of the entire process by which a Federal employee or retiree who is enrolled in a regional alliance health plan would resolve service disputes with his or her plan.

Answer. Under section 1326 of the HSA, each regional alliance must maintain an office of an ombudsman to assist consumers in dealing with problems that arise with health plans and the alliance, including grievance procedures for claimants as provided under Subtitle C of Title V of the Act. Those procedures mandate timely de novo review of denied claims by health plans; review by the Complaint Review Office for the regional alliance (which includes the opportunity to utilize the nonjudicial Early Resolution Program and/or formal hearing before a State hearing officer) after remedies under a health plan have been exhausted; and appeal to the Federal Health Plan Review Board of adverse decisions of the State hearing officer. A decision by the Federal Health Plan Review Board would be binding on all parties, unless the dispute involves an amount in excess of $10,000, which would be appealable to the U.S. Court of Appeals.

Question 18b. Please describe what role that the employing agency and the Office of Personnel Management would have in providing advice, information, guidance, or assistance to the aggrieved employee.

Answer. The employing agency, as it frequently does now with local HMO's and local Blue Cross and Blue Shield plans, could establish an informal relationship with plan personnel to facilitate problem resolution. Disputes resolution procedures would be clearly explained in the informational materials provided by the alliances and the plans. In addition, employing agency staff also would be familiar with the procedures, as they are now, and could provide both clarifying information and guidance if necessary.

Question 18c. Please describe what duties OPM would have in monitoring the experience of federal workers in the State-operated regional health alliances and the quality of service received by them.

Answer. OPM would have no official oversight role once Federal employees are integrated into the regional alliances.

Question 19. What administrative employee health benefits functions now carried out by OPM's program staff would remain centralized after January 1, 1998, and what functions would be delegated to employing agencies?

Answer. Most of OPM's administrative functions, including contracting for the comprehensive benefits package, developing and distributing informational materials, and collecting and disbursing premiums will be handled by the regional alliances. Employing agencies will transmit premium payments to the carriers through the regional alliances rather than through OPM. Employing agencies will receive guidance from the alliances rather than through OPM regulations and policy issuances.

OPM will continue to contract on a limited basis for supplemental and Medigap policies and for plans for Federal employees and retirees living overseas. OPM also will continue to be the employing agency for CSRS and FERS annuitants and will continue to be responsible for maintaining their enrollments and withholding and disbursing their premiums.

Question 20a. Section 8205(c) of the bill deals with the Retired Federal Employees Health Benefits Program [RFEHBP]. Please explain what subparagraph (B) of section 8205(c)(2) means.

Answer. Since "annuitant" is defined for purposes of Subtitle C of Title VIII of the HSA by reference to the FEHB law, this section gives beneficiaries under the RFEHBP annuitant standing for HSA purposes.

Question 20b. Please explain what the language in the second parenthetical statement means and the policy behind it.

Answer. The text in the second parenthesis intends to preserve benefit disparities between the FEHBP and the RFEHBP. However, we note that Public Law 93–246, approved January 31, 1974 (88 Stat. 4), granted OPM regulatory authority to permit RFEHB enrollees to transfer to the FEHBP (due to erosion of the value of RFEHB coverage), and since 1978 there has been an unrestricted opportunity for RFEHB beneficiaries (most of whom are in their 80's and 90's) to elect FEHB coverage (5 CFR, Part 890, Subpart F).

Question 21a. Will a State health care system be approved under subpart B of title I, subtitle F of HR 3600 if the regional alliances being proposed will not have the administrative capacity on January 1, 1998, to absorb all of the Federal workers, retirees, and dependents in the State?

Answer. No.

Question 21b. If the State cannot demonstrate that the alliance health plans and their providers have the capacity to serve all of the Federal workers, retirees, and dependents in the State?

Answer. No.

Question 22a. Under section 6123 of H.R. 3600, a premium discount is available to certain employers, but is not available to the Federal Government until the year 2002. Why? After the premium discount becomes available in the year 2002, is there a phase-in of the premium discount for the Federal Government?

Answer. Premium discounts to limit an employer's contributions to regional health alliances to 7.9 percent of employer wages (less for certain small employers) would not apply to any governmental entity prior to the year 2002. Beginning in 2002, State and local governments would be eligible for premium discounts. However, the Administration never intended for such discounts to apply to the Federal Government. Section 6123 reflects an error; it should completely exclude the Federal Government.

Question 22b. What is included in the term "wages" as used in section 6123 (a) and (b)? (e.g., regular pay? overtime? benefits?)

Answer. The term "wages" is defined in the Health Security Act (section 1901(a)) according to section 3121 of the Internal Revenue Code of 1986. The term "wages" does not include the value of benefits.

Question 23a. Using the most recent complete fiscal year data available, please provide the committee the following: The percentage of wages that the ten largest employing agencies paid toward the cost of health benefits for its employees under the FEHBP.

Answer. The following list represents agency FEHBP contributions as a percentage of total basic pay [1] costs for the ten largest employing agencies (excluding the Postal Service) for Fiscal Year 1992.

Department of Army: 5.6 percent.
Department of Navy: 5.9 percent.
Department of Veterans Affairs: 6.0 percent.
Department of the Air Force: 6.1 percent.
Department of the Treasury: 6.0 percent.
Dept. of Health and Human Services: 4.9 percent.
Department of Justice: 5.6 percent.
Department of Agriculture: 6.1 percent.
Department of Transportation: 5.1 percent.
Other Department of Defense Activities: 5.1 percent.

Question 23b. Using the most recent complete fiscal year data available, please provide the committee the following: The percentage of wages paid toward the cost of health benefits of the Federal agencies that would be eligible for small employer discount under section 6123 (b) and (c).

Answer. As explained in the answer to question 22, Federal agencies would not be eligible for employer premium discounts.

Question 24a. On December 9, Dr. Feder testified before the Energy and Commerce Subcommittee on Health and Environment. She commented at that time on the percentage of the population that would be participating in the regional alliances and the corporate alliances under H.R. 3600. What percentage of the popu-

[1] Basic pay costs include the salaries for all employees, including those not currently covered by the FEHB. These costs do not include premium pay, cash as overtime, holiday pay or cash awards.

lation will be enrolled in State regional alliances, corporate alliances, and in Medicare?

Answer. The majority of Americans will enroll in regional health alliances. There are several factors which will ultimately affect how the population enrolls under the Health Security Act. For example, it is unknown at this time how many states will choose single-payer options. States which do choose this option will not have corporate alliances, and may, upon securing a Federal waiver, fold all Medicare recipients into the state system.

Similarly, the percentage of employees enrolled in corporate alliances will depend on how many corporations will choose to opt out of alliances by forming corporate alliances and how many families with dual earners choose to join a regional Alliance. At the present time, 1200 corporations exceed the 5,000 minimum number of employees to be eligible to opt out. These 1200 corporations employ approximately 22 million workers. Since 7 million of these workers have spouses who work for small firms, anywhere from 15 million to 29 million workers could be covered under corporate alliances depending upon the choices people make. Including Taft-Hartley plans, it is estimated that the maximum number of workers covered under corporate alliances would be approximately 32 million.

Approximately 35 million people (in 1991) are currently enrolled in Medicare. They will continue to enroll in Medicare under the plan unless they or their spouses work, in which case they will remain in their regional or corporate alliance health plan. Approximately five million Medicare beneficiaries are estimated to work or to have working spouses.

Nonworking Medicare enrollees may also remain in their regional alliance plan if that plan qualifies as a Medicare risk contractor. In these instances, the Medicare beneficiary would pay the difference between Medicare's contribution to plans and an actuarially adjusted alliance premium. At this time, we do not know how many Medicare-eligible people might opt to stay in regional alliances.

Question 24b. For the following thresholds (for opting out of the regional alliances), what percentage of the population would be in the regional alliances, corporate alliances, and Medicare:

(A) Threshold of 2,500 employees;

(B) Threshold of 1,000 employees;

(C) Threshold of 500 employees; and

(D) Threshold of 100 employees;

Answer. The Department's Assistant Secretary for Planning and Evaluation is preparing a table which will provide this analysis. We will provide the table when it becomes available.

Question 25. Representatives from Hewitt Association testified on November 22, 1993, at a hearing of the House Subcommittee on Health and the Environment. In their written testimony, they made the assumption that "The Medicaid and uninsured population would cost, on average, 20 percent more than the current insured population." Does the administration agree with the assumption, and if not, why not?

Answer. It is generally true, on average, that per capita health expenditures for the Medicaid population are higher than for the privately-insured population. This may differ considerably from one geographic area to another. We do not understand fully the reasons for this.

It is important to note, however, that under the Health Security Act, we do not expect the integration of Medicaid into private health insurance to affect premiums for the privately insured significantly. This is because the premium States contribute to the alliances on behalf of Medicaid recipients is based on historical expenditures. The premium would be equal to Medicaid's current per capita spending for its enrollees, reduced by five percent to account for lower administrative costs and better management of care, and then indexed.

Question 26. Please explain how under H.R. 3600 the premiums paid by individuals over age 65 who are either working or are retired but not Medicare-eligible would be established.

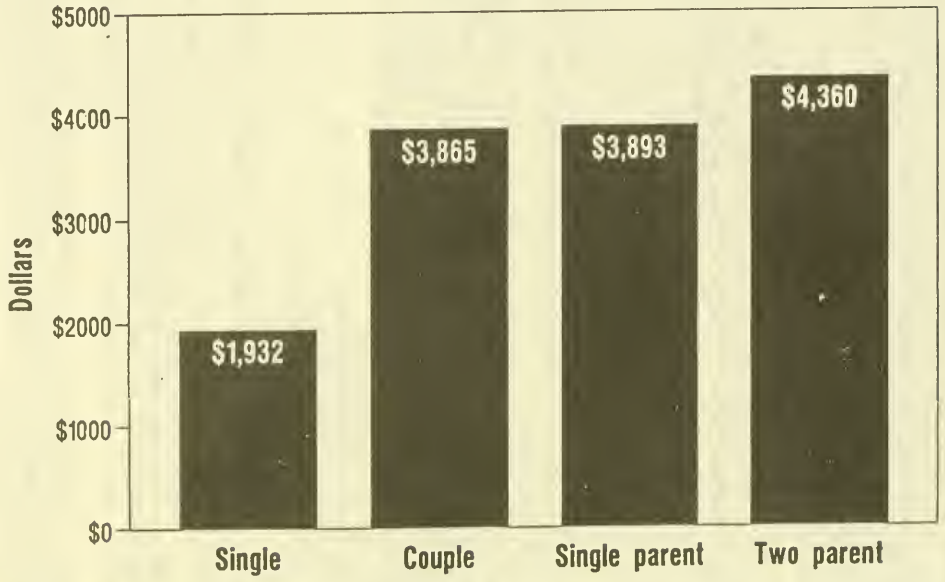
Answer. Premiums for workers over 65 and retirees who are not Medicare-eligible will be established in the same ways as for everyone else: by community rating.

Question 27. Please provide the committee with any technical or editorial changes in the sections of H.R. 3600 dealing with Federal employee and retiree health benefits that the administration would like to propose.

Answer. Any proposal that is as far-reaching and complex as the President's Health Security Act is certain to require technical and clarifying changes as it moves through the legislative process. We appreciate the Committee's strong interest in how the HSA will affect FEHB enrollees and we will be pleased to health care system.

Premiums in Regional Alliances

National Averages by Family Type



Source: HCFA; Office of the Actuary

Attachment #2

THE WHITE HOUSE

WASHINGTON

December 14, 1993

Memorandum for Members of Congress

From: Steve Ricchetti, Deputy Assistant to the President for Legislative Affairs

Subject: Materials on the Health Security Act

Enclosed please find three documents regarding the methodology and assumptions used in preparing estimates on the Health Security Act. These documents include methodological information on the development of premiums and discounts; an executive summary on how the Treasury Department prepared its revenue estimates, and a paper prepared by the Office of Management and Budget describing the budget impact of the Health Security Act and the assumptions and methodologies used to derive the estimates.

We have all enclosed information on a study prepared by Lewin-VHI analyzing the financing of the Health Security Act.

We hope you find this information useful. If you have any questions, please do not hesitate to call the primary Congressional contacts for health reform:

Senate: Chris Jennings 456-2645
House: Jack Lew 456-2316

Methodological Description of Health Care Reform Premium and Discount Estimates

Contributions to this paper were made by:

- Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation
- The Office of Management and Budget
- Health Care Financing Administration's Office of the Actuary
- Agency for Health Care Policy and Research
- The Urban Institute's Center for Income and Benefits Policy

Contents

I. Background

Estimates of premium costs, national health spending, and government program costs under health care reform have been necessary in the decisions leading to a health care reform bill. During the basic policy development process, exploration of alternative policies required estimates of the cost impacts of each possible variation. Specific areas included analyses of premium caps, the impacts on businesses of reqiured employer payments, the effects on households of required purchase of coverage, and the budgetary effects of the discount schedules.

The development of estimates of this type is obviously a complex task. Given that no single authoritative data set exists which captures all spending for all services through all sources of funding, numerous data sources were used in this process. Federal surveys, especially the National Medical Expenditure Survey (1987), offer the best characterizations of national spending. The National Health Accounts generated by the Health Care Financing Administration (HCFA) summarize the best available data on total national spending by type of service and source of fund. Producing estimated spending under health reform, however, requires developing a comprehensive baseline summary for literally hundreds of affected sub-populations, and then estimating the future spending patterns associated with the reform.

Estimates of future costs of reform are primarily derived through modeling transfers of current spending among the various channels of payment. Estimating the impacts of changing primary payers is relatively straightforward, given a baseline of national health spending. More difficult is estimating the net impacts of fee upgrades and paying for uncompensated care, since reimbursement levels will be set to achieve some amount of recapture of these increased outlays for current services. Also difficult is estimating the induced spending attributable to new or enriched insurance coverage. Estimates have been based upon experiences of government and private insurers as well as the results of academic studies of the demand for medical care.

Multiple data sources, methodologies, and models were needed to produce estimates of premiums, discounts, and the overall effects of reform options. Major contributors included the Health Care Financing Administration's (HCFA) Office of the Actuary (OAct), the Agency for Health Care Policy and Research (AHCPR), the Treasury Department, and other government agencies. Numerous consultants assisted in the process, with major modeling contributions provided by the Urban Institute. This paper provides an overview of the major models and their ways of estimating premiums, discounts, and overall health spending under health care reform.

II. Description of the Major Models

A. The Urban Institute's Transfer Income Model (TRIM2):

The Urban Institute has developed a microsimulation model called the Transfer Income Model (TRIM2). This model has been used to analyze the financing of national health care reform plans, and has particularly focused on the distributional effects of such proposals. TRIM2 is based upon the March 1992 Current Population Survey (CPS) and combines data from a number of other sources in order to provide a complete basis for assessing acute care health spending by the non-elderly in the U.S. population.[1] The complete model has been aged to 1994, and all results are presented in 1994 dollars. The following description of TRIM2 and its capabilities has been adapted from Zedlewski, Holahan, Blumberg, and Winterbottom (1993).

The TRIM2 model simulates the employer-based group health insurance system, nongroup or individually purchased health insurance, out-of-pocket spending, and the Medicaid program. The model assigns spending under these programs/systems at the individual and family levels and adjusts for regional variation in premium levels. It is then possible to

[1]Historically, TRIM2 has been used to analyze current and alternative tax and transfer programs. See National Research Council (1991) and Lewis and Michel (1990) for a more complete description of the properties of this model and its recent applications.

assess the distributional effects of the financing of the current health care system. Detailed tax calculations allow the analysts to examine health spending on an after-tax basis and to calculate the after-tax value of employment-based health benefits. TRIM2 can also be used to simulate the distribution of health spending and health care financing burdens under alternative assumptions about how insurance would be provided and financed. Each component of the basic model is presented below.[2]

1. **Employment-Based Group Health Insurance.** TRIM2 examines reported insurance coverage for individuals and families on the CPS to determine the number of family members who share coverage under an employment-based policy.[3] The model assigns an employment-based health insurance premium, including the shares paid by the employer and the employee, to each covered worker based on two 1989 private, employer-based surveys (from the Health Insurance Association of America and Foster-Higgins) and federal health insurance plan documents. These private surveys represent firms of different sizes, in all major industries (including state and local government), and in all regions of the country. Federal health insurance plan documents include information about premiums for single and family coverage and how these premiums are distributed between the employer and worker. TRIM2 statistically matches workers to health plans based on variables that the employer insurance plans and workers on the CPS have in common. These include the type of coverage (single or family), location, industry, the size of firm, and whether or not the worker has to pay part of the insurance premium.

2. **Private, Nongroup Health Insurance.** TRIM2 estimates premiums for the families and individuals on the CPS who report insurance coverage through private, nongroup, health insurance policies. It does this by matching these people with plan data collected from Blue Cross and Blue Shield Plan offices across the U.S. Plan documents included premiums for typical health insurance plans covering single individuals, families, and dual (adult and child)

[2]Giannarelli (1992) describes the full TRIM2 model.

[3]Zedlewski (1991) describes this model in more detail.

insurance units in each state. The method does not, however, capture differences due to families' insurance preferences or income levels. For example, if low (or high) income families reporting private, nongroup health insurance are more likely to purchase catastrophic policies, the model will overstate their premiums. Conversely, the model will understate premiums for families who prefer broader coverage than that included in the prototypical plan.

3. **Medicaid.** TRIM2 uses detailed sets of algorithms to replicate the rules of state Medicaid programs.[4] These algorithms identify Medicaid eligibles as all persons who meet the states' categorical, asset, and income criteria in effect July 1991. The model has procedures for selecting Medicaid enrollees from those who are eligible. The second part of the model imputes the insurance value of Medicaid. Separate estimates are made for adults, children, and the disabled; estimates also vary by age, sex, race, urban or rural residence, reason for enrollment, and number of months in the program. The model uses Medicaid state expenditure data to adjust for differences among states in program generosity and the cost of health services.

4. **Out-of-Pocket Spending.** The model uses data from the Consumer Expenditures Survey to predict out-of-pocket spending (other than health insurance premiums) for families on the CPS.[5] Separate equations were estimated for persons with private insurance coverage, Medicaid, and for those uninsured. The equations predict the incidence and levels of spending as a function of families' socioeconomic characteristics including region of residence, income, the age-sex distribution of family members, and the family head's marital status, education, race, and work status.

5. **Income and Payroll Taxes.** The model calculates family disposable income and estimates the amount of income and payroll taxes required to finance health care spending by

[4]See Holahan and Zedlewski (1989) for a full description of this model.

[5]See Wade (1991) for a full description of this model.

the federal government through the Medicaid and Medicare programs. Other federal taxes (such as corporate, estate, and excise taxes) are not included.[6] The portion of Medicaid and Medicare spending that is financed through the federal personal income and payroll tax systems is calculated and can be allocated to families. The model can also calculate income and payroll taxes under the assumption that employer-paid health insurance premiums are taxable to estimate the tax value of this employee benefit.

6. Total Health Care Spending for the Nonelderly. The TRIM2 baseline distribution of direct spending from various sources accounts for most health spending for the nonelderly. The TRIM2 model excludes the institutionalized population. In addition, Medicare benefits for the nonelderly and military health benefits are excluded. Nevertheless, the model accounts for nearly all of the spending under systems that would be most affected by health care reform alternatives currently under debate.

7. Adjustments to TRIM2 Baseline Output. Two significant adjustments were made to the TRIM2 baseline health spending simulations at the request of the office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS). Both employer health insurance premiums and private nongroup health insurance premiums in TRIM2 were downwardly adjusted to reflect health care reform premiums estimated by the Office of the Actuary (OACT). The TRIM2 employer plan data include employer spending for dental care and a few other benefits that not fully covered by the reform package. Without this adjustment for differences in coverage, employer and family spending under reform as calculated in TRIM2 (using HCFA OACT premiums) would not be comparable to employer and family spending under the current system according to TRIM2. Thus, estimated changes in spending under reform compared to current spending would be distorted without reconciling the spending levels.

[6]However, the TRIM2 model does have the capacity to simulate excise tax payments on alcohol and cigarettes.

B. The Health Care Financing Administration's Special Policy Analysis Model (SPAM):

The Health Care Financing Administration's (HCFA) Special Policy Analysis Model (SPAM) database is also based upon the March 1992 Current Population Survey (CPS). The March 1992 CPS acts as the host file, with each person on it being statistically matched to a person on the 1987 National Medical Expenditure Survey (NMES). Health expenditures and utilization from the NMES person record are then linked to the CPS record, and the entire data set is controlled to be consistent with 1994 National Health Account data.

The parameters used in the linking the NMES file to the CPS were disability status (disabled or not), age and gender (male adult < 19, male adult 19-44, male adult 45-64, male adult 65+, female adult < 19, female adult 19-44, female adult 45-64, female adult 65+, dependent child < 19, and dependent child 19+), family income (family under 100% of poverty, family 100% to 185% of poverty, family at or above 185% of poverty), and insurance class of the person (employer sponsored insurance and Medicare, employer sponsored insurance and Medicaid, other employer sponsored insurance, Medicare and Medicaid and other private insurance, Medicare and Medicaid, Medicare only, Medicaid and other private insurance, Medicaid only, other insurance, and uninsured).

For a CPS person to be considered disabled, one of the following situations had to be true: (a) person was a veteran, collecting veteran's disability, (b) person collected over $10,000 in workers compensation, (c) person had disability income, or (d) person was under 65 and had SSI income. For a NMES person to be considered disabled, one of the following had to be true: (a) person was a disabled veteran, (b) person didn't work due to disability/illness, or (c) person was without a job due to disability/illness.

The determination of adult vs. child was made from "insurance families," which were appended to both the CPS and NMES files. These families were created using standard insurance industry definitions. Within an insurance family there can be one or two adults (single or married couple), and any number of dependent children (or none).

The insurance classifications were hierarchical, and made on the person level using the appropriate variables on both the CPS and NMES. NMES insurance classifications were converted from round data[7] to "ever insured" data (for example, if a person had Medicare in one of the rounds of the NMES survey, they were coded as having Medicare). Poverty classifications were calculated by adding income of all insurance family members together and comparing it to the appropriate poverty standard for the year in question (1991 for the CPS and 1987 for NMES), for the appropriate family size.

Once each CPS person was linked to a NMES record, expenditure data by service (hospital inpatient, hospital outpatient, etc.) and source of payment (out-of-pocket, private insurance, Medicare, Medicaid, etc.) were attached. This file was then aged to 1994 through two steps. First, the 1992 CPS population was weighted to sum to the 1994 Social Security Administration (SSA) non-institutionalized population (about 20 million more than Census estimates). This was done by age (20 age groups), gender and marital status (single, married, divorced, and widowed).

Second, the total national health expenditures by this SSA-weighted CPS population (the SPAM population) were then "benchmarked" by service category, channel of payment, and age category to the aggregate totals in the projected 1994 National Health Accounts. There are 13 service categories: hospital inpatient, hospital outpatient, hospital emergency room, physician inpatient, physician outpatient, physician emergency room, physician office visit, other professionals, prescription drugs, home health care, dental, vision, and other durable medical equipment. There are eight channels of payment: private health insurance, out of pocket, Medicare, Medicaid, other federal, other state and local, workers compensation, and other private. There are three age categories: under 19, 19 to 64, 65 years and over.

An example of how this benchmarking worked is as follows. Suppose the ratio of current

[7]NMES-2, described more fully in the following section, involves 4 surveys of each family over a period of 16 months. Each of the 4 interview sessions is referred to here as a "round."

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SPAM out-of-pocket inpatient hospital spending for persons under age 19 to NHA-consistent spending for the same cell is 0.9. Then each SPAM person's inpatient hospital spending total is multiplied by 1.11. The only divergence from this logic was that out-of-pocket spending for the uninsured was controlled separately from out-of-pocket spending for the insured population (which was thought to have risen at a rate closer to the rate of inflation in insurance).

C. The Agency for Health Care Policy and Research's Simulation Model (AHSIM):

AHSIM is based on AHCPR's 1987 National Medical Expenditure Survey (NMES-2), which is the most recent national effort to collect comprehensive, person-level profiles of health care use, spending, and insurance coverage. AHSIM currently is designed only to analyze the nonelderly (under 65), noninstitutionalized civilian population residing in the United States. Although the NMES-2 data were collected in 1987, demographic variables have been aged forward by reweighting individual records. New weights take into account changes in the distribution of the population by age, race, sex, insurance status, and poverty status observed between the November 1987 and March 1992 Current Population Surveys. Additional demographic aging is based on Census projections of the population by age, race, and sex beyond 1992. Real growth in service-specific health expenditures and insurance premiums have been incorporated through adjustments based on the appropriate rates of changes in HCFA's National Health Accounts and its projections.

AHSIM draws primarily on the NMES-2 Household Survey and its two derivative components, the Health Insurance Plan Survey (HIPS) and the Medical Provider Survey. The Household Survey sample is representative of the civilian noninstitutionalized population of the United States in 1987. Each family in the Household Survey was interviewed four times ("rounds") over a period of 16 months to obtain information about the family's health and health care during calendar year 1987. Roughly 35,000 individuals and 14,000 households completed all rounds of data collection. The Medical Provider Survey obtained information directly from the physicians, hospitals, and other providers used by a portion of the household

sample. These data were used to edit and supplement household survey data describing use of and spending on health services. HIPS data were collected from employers, unions, and insurers and include premiums paid by all sources and specific provisions of baseline private insurance coverage. They also provide information about the organizations offering insurance coverage and include in the case of employers, firm and establishment size, industry, and location.

Other data sources were incorporated when needed for specific purposes. For example, survey data from the Health Insurance Association of America were used to project market shares for fee-for-service, HMO, and preferred provider health plans by region. Annual survey data from the American Hospital Association were used to determine the allocation of hospital spending between inpatient and outpatient services and to identify local areas in which at least one HMO is operating. County Business Patterns data were used to impute average payroll for employers, using a statistical match based on industry, location, and firm size. The Internal Revenue Service (IRS) Statistics of Income (SOI) data were used to expand NMES-2 income data and to calibrate the AHSIM tax module. Further details of the basic AHSIM Model are presented below.

1. Employment-Based Group Health Insurance. AHSIM does not model employers, only households and individuals. HIPS and Household Survey data measured the scope of employment-based insurance in 1987, as well as the allocation of premiums among employers, employees, and other sources (primarily unions). AHSIM assumes that any changes in the pattern of availability, benefits, premiums, or other plan provisions between 1987 and 1994 are controlled for in the aging process, using CPS and HCFA aggregate data.

2. Private, Nongroup Health Insurance. AHSIM handles people with private, nongroup insurance in the same way as it does those with employment-based insurance. This means, for example, that a tendency for people with systematically higher medical expenditures to purchase private, nongroup health insurance will be captured in the model.

3. Medicaid. NMES-2 measured Medicaid program participation directly. Since 1987, however, Medicaid eligibility has been expanded to include low-income pregnant women and children who are not otherwise categorically eligible. This Medicaid expansion was incorporated into the ASHIM model by identifying household survey respondents who would have become eligible for Medicaid benefits by 1994 and modifying their baseline insurance status accordingly. Baseline health spending for new Medicaid recipients was also modified to reflect the effect of a changes insurance status, using the same methods that were used to project estimates for the uninsured after reform.

4. Out-of-Pocket Spending. NMES-2 directly measures baseline out-of-pocket (OOP) spending on cost-sharing and noncovered services for all household survey respondents. However, because the AHSIM model cannot use actual NMES-2 expenditure data directly, data on OOP spending reported in the household survey are used to develop a set of estimates that can be incorporated into the model.[8] In particular, a system of equations was estimated to predict the percent of expenses paid out-of-pocket in the baseline as a function of demographic characteristics, insurance coverage, health status, and other relevant explanatory variables. These equations were then used to impute baseline OOP spending as a percent of imputed total spending, by type of service. While baseline expenditures are imputed in the AHSIM Model, they are still internally consistent with the rest of the NMES-2 data because the estimation procedures preserve the pattern of spending observed in the original household survey data.

5. Income and Payroll Taxes. The AHSIM model distinguishes between households and tax filing units. The effect of wage changes induced by employer mandates on federal

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[8]Actual NMES-2 expenditure are not used as baseline spending in the AHSIM Model for two reasons. For some people, e.g., those affected by the expansion of Medicaid eligibility, baseline insurance status is different than what is was in 1987 when the NMES data were collected. In addition, it is important that reform expenditures only differ from baseline for reasons related to reform. Because reform expenditures must be predicted for people based on their "new" insurance status, it is helpful to predict baseline spending with the same methodology.

personal income and payroll taxes can be calculated with respect to the 1991 tax treatment of employer paid premiums.

6. Total Health Care Spending for the Nonelderly. The AHSIM baseline includes most health spending by the civilian, resident population of the United States under the age of 65. AHSIM excludes the institutionalized population, Medicare beneficiaries among the nonelderly, and spending by active-duty military personnel.

7. Adjustments to AHSIM Baseline Data. Because the aggregate health insurance premiums reported in the HIPS component of NMES-2 are not consistent with the benefits paid by private health insurance according to either the Household Survey or the National Health Accounts, the NMES-2 HIPS-based premiums are calibrated to these other data sources. Tax estimates and wage income are calibrated to SOI data, as described above. In general, according to extensive analysis by HCFA and AHCPR staff to account for differences in definition and coverage, the NMES-2 expenditure data and the National Health Accounts yield similar estimates.

III. Premium Estimation Under Reform

Two agencies, the Health Care Financing Administration and the Agency for Health Care Policy and Research, estimated the cost of health insurance premiums under reform. Their estimates are in 1994 dollars and reflect the benefits included in the standard benefit package. The premium estimation methodology used by each of these agencies is described below.

A. Health Care Financing Administration:

The first step in HCFA's simulation process was to determine each individual's insurance status. The modelers used CPS indicators for this, and considered a person to be insured if he/she was covered by employer-sponsored insurance, other private insurance, CHAMPUS, Medicare, or Medicaid. Insurance could be either in one's own name or through inclusion in a policy held by an adult in the insurance unit. Also, some dependents are covered by private insurance policies owned by people outside the family (for example, a child of divorced

parents may be covered through insurance carried by the parent who does not live with the child).

HCFA modelers then adjusted health expenditures to reflect the coverage offered through the regional alliance plan. That coverage is restricted to hospital care, physician and other professional services, prescription drugs, and durable medical equipment other than vision and hearing products. Therefore, the analysts excluded all other National Health Accounts expenditure categories. The cost of coverage for mental health, dental, and preventive care in the standard benefit package was estimated separately, from aggregate data, and added in at the end of the process. Once expenses were adjusted for coverage differences, the modelers applied the fee-for-service plan deductibles, coinsurance, and cost-sharing limits to each person covered through the regional alliance.

An insurance-induced demand adjustment was applied to all those enrolled in the regional alliance. The basis for the induced demand was the difference between out-of-pocket spending under current law and that determined by the reform simulation described above. The induction factor varied by type of service. The application of the factors and the specific values used are described in appendix A. Post-induction spending is equal to the expenditures calculated previously plus (minus) the induced spending calculated as described.

Following these steps, HCFA analysts imputed expenses to currently uninsured people. Existing patterns of use for the uninsured person were discarded, because those patterns are influenced by the absence of insurance. An imputation file was created for each service covered under the regional alliance. To create the file, insured people (excluding people who received SSI cash payments) were divided into groups according to gender, four age classes, and three poverty status classes. Expenditures were tabulated for each group to determine: (a) the proportion that had no expenditure and (b) mean expenditures and use for each decile of the user distribution.

Expenses were imputed for an uninsured person using these imputation files. For each

type of service, the person was assigned a random number ranging from 0 to 1. If that random number fell within the nonuser proportion for the service, the person was given no expenditure for the service. Otherwise, the person was given the mean expenditure and use for the decile of users into which the random number placed them. Analysts assumed that facility and physician use was correlated for hospital services, and used the same random number for hospital inpatient and physician inpatient use. They did the same for hospital outpatient and physician outpatient, and for hospital emergency room and physician emergency room use.

Analysts performed a final simulation to determine which people were covered by the alliances. Typically, they excluded people who received AFDC or SSI cash payments. Similarly, most Medicare enrollees were excluded; only those who worked or whose spouse worked were included in the premium calculations. The remaining people were divided between the corporate alliance and the regional alliance according to the worker status of the adults in the insurance family, and were assigned to one of three policies: individuals (and couples with no dependents), one adult plus dependents, and two adults plus dependents. In a final pass through the family's health expenditures, analysts applied the family limits on out-of-pocket spending to determine the plan benefits and copayments.

In order to generate an upper-bound discount estimate, whenever a two-earner couple had one worker in a large firm (5,000 or more workers) and one in a firm that would be covered through a regional alliance, the couple was assumed to choose coverage in the regional alliance. This maximizes the potential cost of the discounts costs given that no government discounts are available through the corporate alliances.

After plan benefits had been determined, premiums were calculated for each of the policy types and alliance types. An offset was applied to expenses to reflect current-law cost-shifting attributable to uncompensated care. Under the current system, private sector premiums are higher than they would be if there were no uncompensated care in the system since providers pass these unpaid costs on to insured, paying patients. Under reform, all

persons will be insured; consequently, baseline premiums should be reduced to reflect the elimination of non-payers from the system. A load factor was applied to the (reduced) benefit cost per policy. The load factor was 15 percent for the regional alliance.

B. Agency for Health Care Policy and Research:

AHCPR's method of generating premium estimates has seven steps. First, following conventions in health economics, AHSIM estimates a two-part model of expenditures for each service. The unit of observation is the person. The first equation in each service's set of two equations estimates the probability of using the service at all as a function of demographic, income, insurance, employment, and health status measures from the 1987 NMES-2. The second equation estimates annual expenditures on the service for all users of the service, as a function of the same explanatory variables. Combining the result of these equations (i.e., multiplying the probability of use times the coefficients in the second equation) yields an equation that predicts expenditures for each type of person. Predicted expenditures are aged to 1994.

Health expenditures for each person are then predicted for each of the ten services included in the AHSIM Model using this system of equations. Predictions for both the probability and the level (given any use) of an expense were made for each person based on these regressions. The procedure assigns the same expected values to people with private insurance and similar personal characteristics, based on a hypothetical "average" insurance policy. Expected values are modified to take into account specific plan provisions using information from the RAND National Health Insurance Experiment about the effects of such provisions. Reform expenditures are imputed to all people in the model using a stochastic process that maintains observed correlations in expenditures across service types while controlling for the demographic characteristics and health status of individual NMES-2 respondents.

Every individual included in the AHSIM Model actually had three types of reform expenditures assigned to them, indicating their (assumed) behavior under fee-for-service

(FFS), managed care (HMO), and preferred provider (PPO) insurance arrangements. Expenses for benefits paid, cost-sharing and noncovered services were calculated separately for each type of plan by applying claims-processing logic to the appropriate estimated expenditure. Premiums for each type of insurance plan were computed on the basis of average benefits paid per insurance policy plus an administrative load set at a percent of benefits paid. In this way, each person was taken into account in computing initial premium levels. Premiums were adjusted for current regional variations in prices.

Individual choice of health plans under reform was modelled by randomly assigning health insurance units to one of the three types of plans (FFS, HMO, PPO) described above. The assumed probabilities of selecting particular plans were based primarily upon market shares observed by HIAA in their annual surveys, trended forward to 1994. These estimates were modified by assuming a 10 percent reduction in FFS under reform as a result of managed competition. Market shares were allowed to vary on the basis of region, urban/rural location, and the availability of discounts for out-of-pocket (OOP) expenses and premiums.

Two passes through the data are made to compute the final set of premiums. The first pass implements decision rules regarding the distribution of premium payments under reform. It also computes the cost of noncovered services and cost-sharing requirements borne by individual households. Based on these calculations, the model determines the extent to which a household's direct costs will be offset by supplemental insurance and OOP discounts. In the second pass through the data, expenditures are increased to reflect additional spending induced by supplemental insurance and OOP discounts. Insurance premiums are then adjusted to reflect these higher expenditures.

C. Choice of Premium Estimates for Budgeting Purposes:

One set of premium estimates had to be chosen for final budgeting purposes. Although AHCPR's premiums were used by that agency in their estimation of discounts to employers and households and those discount estimates were used as a check on estimates done by HCFA and the Urban Institute, the Administration opted to use the HCFA premiums for

purposes of final federal budgeting and distributional effects analyses.

This choice was made for two reasons. First, the premiums estimated by HCFA were higher than those estimated by AHCPR, and it was viewed as desirable to have an official estimate that was more conservative (i.e., that would lead to higher costs associated with the program -- see Table 1 below). Second, the HCFA estimates are benchmarked to the National Health Accounts, the most reliable measure of aggregate spending in the current health care system. Given that the National Health Accounts are considered to be the "gold standard" in measuring total health expenditures, it seemed most appropriate to keep the official premium estimates consistent with that standard.

Table 1

Alliance Premium Estimates

Policy Type:	HCFA	AHCPR
Single	$1933	$1735
Couple	$3865	$3471
One Adult Family	$3894	$3647
Two Adult Family	$4361	$4262

IV. Discount Estimates

The national health care reform plan includes a number of different discounts, targeted at different payers. There are two employer discounts: one directed at all firms in the regional alliance, and one directed at small firms with less than 75 employees. There is a discount for the family share (20 percent of the actuarial value) of premiums and for out-of-pocket

payments for both working and nonworking low income families. There is also a discount for the 80 percent premium share for those families who do not have at least one full time worker (or equivalent), including early retirees. The major models are similar in how they estimate most components.

A. Employer Discounts:

The general firm discount consists of a 7.9 percent of payroll cap on all firm premiums, regardless of firm size, provided the employer is in the regional alliance. If the cost of providing 80 percent of the adjusted premium per worker exceeds 7.9 percent of firm payroll, the share paid by the federal government is equal to the difference between the two amounts, or:

$$[N_S(.8P_S)+N_C(.8P_C)+N_{SP}(.8P_{SP})+N_{DP}(.8P_{DP})]-(.079*\textit{firm payroll})$$

where N is the number of workers of each contract type (S=singles, C=couples without children, SP=single parent families, and DP=dual parent families) and P is the adjusted per worker premium for each contract type.

The small firm discount schedule provides lower payroll caps (less than 7.9 percent) for firms with less than 75 employees and average pay below $24,000 per year. The small firm schedule is shown in Table 2.

Table 2

Small Firm Discounts

Average Firm Payroll	Size of Firm[9] (Number of Employees)		
	Less Than 25	25 to 50	50 to 75
Less $12,000	3.5%	4.4%	5.3%
$12,000-15,000	4.4%	5.3%	6.2%
$15,000-18,000	5.3%	6.2%	7.1%
$18,000-21,000	6.2%	7.1%	7.9%
$21,000-24,000	7.1%	7.9%	7.9%
Greater Than $24,000	7.9%	7.9%	7.9%

[9]Because 75 workers was not a firm size break included in the data sets being used, modelers were asked to use a firm size of 100 for this subsidy calculation. Given that the subsidies will apply only to firms up to size 75, the results overestimate the subsidy costs.

1. TRIM2: Employer Discounts. In the TRIM2 model, employer obligations (either 80 percent of the adjusted premium for each worker or a percent of total payroll) are calculated for each worker; there are no firms per se on the CPS, although each worker has employer information associated with them. TRIM2 assigns firm average payroll information from the County Business Patterns (CBP) data to each worker, using a statistical matching procedure that relies on industry (the 3-digit SIC codes), state of residence, and establishment size.

In addition, an average firm premium is imputed to each worker. Take, for example, retail firms with 100-500 workers. Assume that according to the CPS, of the workers who report being employed by that type of firm, 40 percent are singles, 20 percent are married but have no children, 30 percent are married with children, and 10 percent are single parents. The weighted average firm premium that an employer of that type faces is equal to

$$(.4P_S)+(.2P_C)+(.1P_{SP})+(.3P_{DP})$$

where P_S, P_C, P_{SP}, and P_{DP} are as described earlier.

The employer's payment is proxied by the comparison of average pay times the appropriate percentage cap (3.5 percent to 7.9 percent) to 80 percent of the average firm premium. If the 80 percent of the average firm premium is less than capped average pay, the employer would pay 80 percent of the correct adjusted premium for each worker. If, on the other hand, capped average pay is less than 80 percent of the average firm premium, the employer would contribute 7.9 percent (or the appropriate percentage less than 7.9 percent) of total payroll to the alliance.

If the firm cap is the less expensive option, the worker's record is appended with an employer payment equal to the appropriate cap times average pay in the firm. The amount paid by the federal government on behalf of the employer is also added to the record in the amount of:

$$(.80P_i) - (CAP * (Avg.\ Firm\ Pay))$$

where P is the adjusted per worker premium for the worker's health insurance unit type i (single, couple, single parent, dual parent), CAP is equal to the appropriate percentage cap (ranging from 3.5 percent to 7.9 percent) and Avg. Firm Pay is equal to the firm's average payroll as imputed from the CBP data.

If, conversely, 80 percent of the adjusted per worker premium is the less expensive option, the worker's record is appended with an employer payment equal to $.80*P_i$, where i is equal to the appropriate health insurance unit type for that worker, and there is no government employer discount.

2. **HCFA: Employer Discounts.** In the SPAM model, the basic calculations of employer discounts are similar to those in TRIM2, other than the development of firm-level average payrolls. While TRIM2 imputes payroll data from the County Business Patterns data set, SPAM uses payrolls created by synthesizing firms from employees on the CPS. For each record of an employee on the CPS, one of the firms created using that employee is linked back to serve as the firm description for that employee. The resulting payroll distribution is similar to that implied by the CBP.

3. **AHSIM: Employer Discounts.** In the AHSIM model, the calculations are also similar to those in TRIM2. AHCPR uses County Business Pattern data for estimating average payroll. The links to NMES-2 make use of the Household Survey detailed responses by firm-size, industry, and other variables, confirmed by the NMES-2 Health Insurance Plan Survey.

B. Discounts for the Self-Employed.

Those individuals who are self-employed are obligated to make a contribution to the alliances based upon the same schedule used to determine small business payments. Those with self-employment income between $0 and $12,000 per year, for example, pay the lesser of 3.5 percent of self-employment income and:

$$(.80*P_i)-EC$$

where P_i is as before and EC is the credit received by the self-employed person due to employer contributions made on their behalf while doing wage work. So, for example, a self-employed person who is also employed by a firm and who is working a full-time, full- year job for wages/salaries has no further obligation with regard to the 80 percent/employer share. An individual who works full time for wages for 8 months and then quits that job and becomes self-employed is only obligated up to a maximum of 4 months of the 80 percent of the adjusted per worker premium for his/her health insurance unit type.

C. Discounts to Low Income Families.

Low income workers and non-workers (those with family income less than 150 percent of poverty[10]) are eligible for government discounts to assist in the payment of the family share of the premium and to assist with family out-of-pocket payments (co-insurance and deductibles). The family premium share discounts work as follows:

1. Those with family incomes at or above 150 percent of poverty are responsible for paying the full 20 percent share, subject to a maximum of 3.9 percent of family income.

2. Those with family incomes below 150 percent of poverty have their premium obligation calculated as:

$$MARG_1(INC_1-1000)+MARG_2(INC_2-INC_1)$$

where INC_1 is equal to the family income up to the appropriate poverty guideline, INC_2 is equal to family income if it exceeds 100 percent but is less than 150 percent of the appropriate poverty guideline, $MARG_1$ is the contribution rate applied to family income below

[10]The family size specific poverty guidelines used are as follows:
single -- family size is 1
couple -- family size is 2
single parent family -- family size is 3
dual parent family -- family size is 4.

poverty, and $MARG_2$ is the contribution rate applied to family income between 100 and 150 percent of poverty.

The two contribution rates are such that families below poverty do not pay more than 3 percent of income for their family premium share contribution, those with income below \$1000[11] have no premium contribution. Families at 150 percent of poverty pay the full 20 percent share, or 3.9 percent of family income, whichever is less. The government payment is equal to 20 percent of the actuarial premium for the health insurance unit type, less the family contribution calculated above. For purposes of this calculation, family income is equal to adjusted gross income less unemployment compensation plus non-taxable interest income.

For each marginal rate ($MARG_1$ and $MARG_2$), there are two sets of rates to be used. The first set ($MARG_{1single}$, $MARG_{2single}$) is applicable for single health insurance units and uses the poverty guidelines for a family of size one. The second set ($MARG_{1other}$, $MARG_{2other}$) is applicable to all other health insurance units and is based on the poverty guidelines for a family of size four.

Set one is calculated as follows:

$$MARG_{1_{single}} = (0.03 * POVG_1)/(POVG_1 - 1000)$$

$$MARG_{2_{single}} = ((0.2 * PREM_s) - (0.03 * POVG_1))/(0.5 * POVG_1)$$

where $POVG_1$ is based on the poverty guidelines for a family of size one, and $PREM_s$ is the premium for a single individual. In 1994, these rates are estimated to be 3.5 percent and 4.8 percent, respectively.

Set two is calculated as follows:

[11] In 1994 dollars. The income "disregard" is indexed by the CPI in future years.

$$MARG_{1\_\_} = (0.03 * POVG_4)/(POVG_4 - 1000)$$

$$MARG_{2\_\_} = ((0.2 * PREM_{DP}) - (0.03 * POVG_4))/(0.5 * POVG_4)$$

where $POVG_4$ is the poverty guideline for a family of size four, and $PREM_{F2}$ is the premium for a dual parent family. In 1994, these rates are estimated to be 3.2 percent and 5.8 percent, respectively.

These rates result in singles and dual parent families paying their full 20 percent premium share at 150 percent of poverty. At 150 percent of poverty, singles pay 3.6% of their income and dual parents families pay 3.9 percent. When the second set of marginal rates are applied to single parents and couples, these families are paying approximately 3.9 percent of their income at 150 percent of their appropriate poverty guideline (family size set at three for single parents and two for couples); however, that amount is less than 20 percent of their respective premiums. Consequently, couples and single parents with incomes in excess of 150 percent of poverty will be required to pay the lesser of 20 percent of their premium and 3.9 percent of income.

An out-of-pocket spending discount is available for those families below 150 percent of poverty who live in an area that does not provide access to a low cost sharing (HMO) plan. In such cases, the family is only obligated to pay the cost sharing that would be required if the family had actually enrolled in an HMO (i.e., $10 copayment for outpatient services); and discounts will be available for the remainder.

Families without at least one full time worker or equivalent[12] may be required to pay at least some portion of the 80 percent adjusted premium share that is covered for workers

[12]Two examples of families with a "full time worker equivalent" are:
1. each spouse works half time for the full year;
2. one spouse works full time for 8 months and the other works full time for 4 months.

through their employers. Families with non-wage income below 250 percent of poverty are eligible for some subsidization of this obligation. If eligible, a family's payment for this portion of the premium is equal to:

$$MARG_3(NWINC_1 - 1000) + MARG_4(NWINC_2 - NWINC_1)$$

where $NWINC_1$ is equal to the family non-wage income up to the appropriate poverty guideline, $NWINC_2$ is equal to family non-wage income if it exceeds 100 percent but is below 250 percent of the appropriate poverty guideline, $MARG_3$ is the contribution rate applied to family non-wage income below poverty, and $MARG_4$ is the contribution rate applied to family non-wage income between 100 and 250 percent of poverty. $MARG_3$ is set such that families below poverty do not pay more than 5.5 percent of their non-wage income for this portion of the premium, and families with less than $1000 in non-wage income have no required contribution towards this portion of the premium. The federal payment is equal to 80 percent of the appropriate adjusted per worker premium less employer payment credits, less self-employment contributions, and less family contributions as defined above.

Non-wage income is calculated as Adjusted Gross Income (AGI) less wages and salaries less unemployment compensation and less self-employed income.[13] Income in this category includes: rents and royalties, interest (including non-taxable interest income), dividends, alimony, capital gains/losses, the taxable portion of social security, partnerships, and trusts. Aside from items mentioned above, other categories of excluded income are: welfare payments, VA benefits, worker's compensation, child support income, inherited money, and proceeds from life insurance.

There are four sets of contribution rates which can be applied to non-wage income: one each for single, couples, single parent, and dual parent families. They are calculated using the formulas shown below, using the family sizes of 1, 2, 3, and 4 respectively to determine

[13]The actual legislation excludes wages and salaries up to $60,000 per year. Wages and salaries in excess of this amount count towards this calculation. The $60,000 exclusion cap was not modelled, making the subsidy estimates somewhat over-stated.

poverty guidelines.

For family type 'i':

$$MARG_{3_i} = (0.055 * POVG_i)/(POVG_i - 1000)$$

$$MARG_{4_i} = ((0.8 * P_i) - (0.055 * POVG_i))/(1.5 * POVG_i)$$

where $POVG_i$ is the poverty guideline for the appropriate family size, and P_i is the appropriate adjusted per worker premium. In 1994, these rates are estimated to be as follows: for singles, 6.4 percent and 10.7 percent; for couples, 6.1 percent and 10.9 percent; for single parent units, 6.0 percent and 9.8 percent; for dual parent units, 5.9 percent and 7.5 percent.

These rates were calculated so that families pay their full employer share of the premium at 250 percent of poverty.

D. Retiree Discounts.

Families with retirees[14] are eligible for a special discount. When fully phased in, government discounts cover the full 80 percent/employer share for non-working retirees. Government discounts are offset to some extent by the employers of retirees who work part time and the employers of working spouses. For example, a 58 year old man who is working half time will have half of his employer contributions made by his employer and half of his contributions will be made by the federal government. No government discount is necessary when a retiree has a full time working spouse, as the spouse's employer's contributions will fulfill the coverage responsibility. However, if a retiree is married to a non-worker, the government contribution will cover the couple (or family).

[14]The policy defines retirees as those nonworkers who have fulfilled a requirement of a minimum number of working quarters and who are between the ages of 55 and 64, inclusive. However, the models being used to simulate the cost of the plan do not have data on quarters worked. Consequently, all individuals 55 to 64, who are not working or work part time or part year, are modelled as being eligible for the special retiree subsidy.

E. Choice of Discount Estimates for Budgeting Purposes and Distributional Analyses:

For reasons noted above in the section on premium estimation, the HCFA premiums were selected as the official Administration estimates. This choice necessitated that a model using the HCFA premiums be used as the official Administration discount estimates. For this reason, the discount estimates used for budgeting purposes are from the HCFA simulation model. It should be noted however, that all three discount estimates were within 7 percent of each other. Consequently, all estimates are well within the discount "cushion."[15]

For purposes of distributional analyses, the Administration's official estimates come from the Urban Institute's TRIM2 model, which was benchmarked to the National Health Accounts and which used the HCFA estimated premiums. The Urban Institute is the most experienced of the three groups in doing the type of complex distributional analyses needed for the reform process.

V. National Spending Impacts

The change in spending produced by health reform can be summarized in terms of the impacts on businesses, households, and governments. Present business spending is here limited to employer contributions for employer-sponsored health insurance and for active workers and retirees. Under reform, employers are required to pay 80 percent of the average worker premium in their area (net of discounts) for most workers. Beyond the required outlays, it is expected that there will be supplementation of the required coverage. Those employers currently paying more than the required employer contribution percentage, or buying richer coverage (e.g., lower cost-sharing) are assumed to continue to pay more than the required minimum.

The calculations of changes in business outlays are similar in TRIM2 and SPAM. If an

[15]The HCFA discount estimates were increased by 15 percent in an effort to budget a more conservative level of discounts.

employer currently pays more than 80 percent of premiums, TRIM2 increases employer spending under reform to match the proportion contributed by the employer currently, as long as this does not exceed current spending. If maintenance of the current proportion would exceed current spending, it is assumed that employers increase their spending only to the point of current spending. Worker contributions are reduced accordingly. This first part of supplementation is then increased to add the cost for enhancing the richness of coverage up to the current level of plan richness associated with each currently insured worker. The cost of matching the current richness of benefits is paid by the employer and the worker in proportion to current premium contributions.

In the SPAM model, additional coverage is assumed wherever current payments are better for the family than modeled future payments under the mandated benefit package. Supplementation amounts are accumulated equal to the difference between current and required benefits. Employer contributions are assumed to cover the supplement, although employer payments for the required coverage are held to the mandated minimum.

The AHSIM Model assumes that both employers and households attempt to hold their spending on health insurance constant from baseline to reform. To the extent that baseline spending on employer-sponsored insurance exceeds expenditures required under reform, employers are first assumed to buy down their employees' required contributions. If baseline spending exceeds reform requirements for either households or employers after taking this transfer into account, the AHSIM model then allows both households and employers to buy supplemental insurance. For each health insurance unit in AHSIM, the actuarial value of supplemental insurance purchased under reform cannot exceed baseline levels. The total amount of supplemental insurance is also limited by the level of potential out-of-pocket expenses (cost-sharing plus noncovered services) under reform. Supplemental insurance is also assumed to carry a higher administrative load than basic health plans, 25 percent in most recent simulations. Any employer excess that remains after buying supplemental insurance is assumed to increase other tax-preferred fringe benefits.

Household spending is defined to be the employee contributions for employer-sponsored health insurance, direct premiums for non-group coverage (under the current system) or direct purchase of alliance coverage (under reform), and cost-sharing payments. In the baseline, the employee contributions are defined to include employee payments irrespective of tax status; pre-tax employee contributions are counted as employee payments despite IRS treatment of such sums as employer contributions. To the extent supplementation implies higher business payments, household spending is reduced by like amounts. Total changes in cost-sharing are calculated as the net of reduced payments due to new and enriched coverage, against increased cost-sharing attributable to required purchase of insurance leading to increased utilization and some personal payments (rather than reliance on uncompensated care mechanisms).

Government spending changes reflect transfers between the Federal government and other levels of government, as well as increased Federal responsibilities (particularly in arranging discounts for low-wage firms). Baseline Federal spending is primarily Medicaid and Medicare. Under reform, Medicaid non-cash populations move into alliance plans, with some direct business payments. Similarly, more Medicare recipients fall under working aged rules, with direct employer contributions reducing Medicare responsibilities.

State and local baseline spending is primarily Medicaid, although significant sums are currently spent on other programs, most notably direct payments to hospitals. Under reform, Medicaid savings will be redirected under maintenance of effort requirements for use in paying for discounts for low-income populations in the alliances.

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APPENDIX A

Example of the Application of an Induction Factor To a Change in Insurance Status

	Before Change	After Change
Current law spending	$200	$200
Multiplied by copayment rate	x 50%	x 20%
Out-of-pocket spending	$100	$40
Initial change in out-of-pocket		$60
Multiplied by induction factor		x 0.7
Equals change in total spending		$42
Current law spending		$200
Plus induced demand		42
Equals new total spending		242
Less new out-of-pocket (20%)		- 48
Equals new benefits		194

Induction Factors Used in SPAM Simulations

Hospital inpatient (facility and physician)	0.3
Prescription drugs	1.0
Emergency room services and DME	0.0
All other services	0.7

SOURCE: Office of the Actuary
Health Care Financing Administration

December 9, 1993

ESTIMATING THE IMPACT OF HEALTH REFORM ON FEDERAL RECEIPTS

Executive Summary

The Treasury Department's Office of Tax Analysis (OTA) is responsible for preparing revenue estimates of proposals which affect Federal receipts. In general, OTA analyzes legislative proposals that change the Internal Revenue Code. OTA also analyzes the effects of certain legislative changes which do not amend the Internal Revenue Code but nonetheless affect Federal receipts. For example, changes in the laws concerning employer provision of certain fringe benefits can affect receipts because of the favorable tax status of such benefits.

The tax code also provides preferential treatment for certain types of health insurance expenditures. Health insurance contributions receive preferential tax treatment under several different provisions. Employer contributions for health insurance are deductible as a business expense by the employer and are excluded from the income of employees. Through their employers, some employees may have the option of contributing to tax-preferred cafeteria plans, enabling them to pay for their portion of health costs with pre-tax dollars. Self-employed individuals can deduct 25 percent of health insurance costs from adjusted gross income. Taxpayers can also deduct qualifying medical expenses which exceed 7.5 percent of their adjusted gross income. As a consequence, changes in the financing of health insurance will have implications for Federal receipts.

Estimating the effects of health reform on Federal receipts has required a cooperative effort among many agencies. The undertaking has demanded a broad understanding of the provisions contained in the proposal. Estimating the revenue impact of the proposal has required many data inputs from other Federal agencies involved in this process. To maintain consistency while estimating the costs of the health reform plan, the estimates of the revenue impact of the plan rely on certain inputs from other Federal agencies involved in this process. Because of the interaction among the provisions, a change in one or two of the basic underlying policy parameters could trigger significant changes in the revenue estimates.

The health reform plan contains many non-tax provisions which may affect Federal receipts by changing the financing of health care. Each of these provisions may have very different effects on revenues, but in combination the Administration's plan results in a net increase in Federal receipts over the budget period. An alternative plan with similar features could yield very different revenue results, even if it differed from the Administration's plan in only a few key non-tax aspects.

This technical note provides background as to the methods and assumptions underlying Treasury's estimates of the impact of health reform on Federal receipts. In preparing these estimates, Treasury followed long-standing estimating conventions accepted by both Administration and Congressional agencies responsible for producing estimates of the budgetary impact of legislative proposals. In analyzing the revenue impact of non-tax changes in the financing of health insurance, Treasury has used the same methodology and models which are used to estimate the effects of changes in Internal Revenue Code provisions on receipts.

Individual Tax Model

The Individual Tax Model (ITM) is one of the most powerful tools developed by OTA to aid in estimating changes in Federal receipts. The ITM is a large microdata simulation model. The microdata aspect of the model refers to the fact that it contains data on the income, deductions, health expenditures, and other characteristics of individual tax filing units and families. The model can simulate the taxes paid under both current law and proposed changes in law.

Professional economists in OTA construct, maintain, and utilize the ITM. OTA economists share a broad background in applied microeconomics, particularly in public finance. In addition, OTA economists are also specialists in other fields, such as econometrics, health economics, labor economics, statistics, and computer programming. These skills are used to develop the inputs to the model and for examining its outputs.

Interactions with Other Agencies with Interests in Tax and Health Policy Questions

OTA economists communicate regularly with their counterparts at the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO), who also use large microsimulation models. Such contacts are useful both for identifying differences among the models as well as for developing consensus among the agencies responsible for analyzing the receipts effects of proposals.

In the health area, OTA staff maintains regular contact with numerous specialists. Members of OTA staff routinely discuss health modeling issues with staff from several agencies in the Department of Health and Human Services, including the Agency for Health Care Planning and Research (AHCPR), the Office of the Assistant Secretary of Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). In addition, OTA consults with health policy staff at the Council of Economic Advisers (CEA), the Office of Management and Budget (OMB), and the CBO.

OTA's extensive contacts with the staffs of other government agencies and outside experts provide additional access to data, research, and other techniques which are generally useful for model development. In many cases, these contacts are long-standing.

Description of the Individual Tax Model[1]

Data: The current version of the ITM was constructed from a sample of 110,000 individual

[1] For a more detailed discussion of the Individual Tax Model, see James Cilke and Roy A. Wyscarver, The Treasury Individual Income Tax Simulation Model. Department of the Treasury, Office of Tax Analysis, March 1990.

income tax returns filed in 1989. The data base is a stratified probability sample of tax returns prepared by the Internal Revenue Service's Statistics of Income (SOI) Division.[2] This is the same sample employed by the SOI to produce the tabulations published in the Statistics of Income - 1989 Individual Income Tax Returns. When weighted, these data represent the total population of taxpayers in the United States.

Tax returns contain extensive information on the components of taxable income. In addition, tax returns provide information about taxpayers' marital status and family size. However, tax returns do not contain information on other demographic characteristics, on non-taxable forms of income such as welfare benefits or earnings on pension and other retirement savings, or on expenditures made by the taxpayer. Nor do tax returns provide any information on families outside the tax system.[3] More comprehensive information than is provided on tax returns is needed to analyze the impact of proposals which extend the current income tax base and to analyze payroll, excise and other taxes.

To add more information, the SOI tax return data are first matched to age data from Social Security records and then statistically merged with records from the Current Population Survey (CPS) conducted annually by the Bureau of the Census. The records in the ITM are grouped into family units as well as income tax return units, and are weighted to represent the entire filing population and noninstitutionized nonfiling population. The SOI file is also statistically merged with records from the Bureau of Labor Statistics' Consumer Expenditure Survey. In addition, imputations of other critical income, asset, expenditure, employment, and demographic measures are made using a variety of sources (e.g., the Federal Reserve Board's Survey of Consumer Finances).

The data sources described above contain only limited information on expenditures on health care. From tax returns, information is available on the amount of health insurance purchased by self-employed persons who claim a 25 percent deduction. Tax returns also contain information on certain health expenditures, but only for those filers who itemize deductions and whose expenditures exceed 7.5 percent of their adjusted gross income. The Current Population Survey provides information on the insured status of individuals, including whether the insurance is provided through private or public sources. Lacking from these surveys is information on a family's total expenditures (including any employer contributions) on health insurance, characteristics of their insurance policy, and the health status of family members.

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[2] Under Section 6103 of the Internal Revenue Code, OTA and JCT have access to tax return data, including the complete SOI file. A public-use computer tape file is available to other analysts, but it has fewer data items and taxpayer records and does not contain information which might violate the confidentiality of taxpayers. In particular, the public use file blurs information on high-income taxpayers.

[3] Nonfilers are predominantly low-income persons who do not have an income tax liability and do not file a return to claim a refund.

To supplement these data sources, OTA statistically matched the data from the 1987 National Medical Expenditure Survey (NMES) to the ITM. The NMES is an extensive survey of approximately 14,000 households representing the civilian, noninstitutionalized population of the United States. It was conducted under the auspices of the Department of Health and Human Services' Agency for Health Care Planning and Research (AHCPR). The 1987 survey updates and expands previous surveys conducted in 1977 and 1980. The surveys collected information about participants' utilization and expenditures for health services, health insurance coverage, health status, and employment and income. Data from the household survey are supplemented by information from medical providers, employers, and insurers.

Extrapolation: The complete data file is then extrapolated to future years based on the economic forecasts used in the Budget.[4] The extrapolation is done in two stages. The first stage adjusts for anticipated economic growth and inflation. This is accomplished by multiplying the various income, deduction, and credit items on each return by forecasts based on per-capita growth rates estimated from the economic forecasts. In the second stage, the weights assigned to the records in the file are changed to hit separately determined targets for key variables, including the size distribution of adjusted gross income.

The growth rates for health data are generally based on projections contained in the Federal Budget or the National Health Accounts. Where relevant, the targets reflect significant changes in participation or expenditures since 1987 (the base year for the NMES) or 1989 (the base year for the CPS). For example, a major expansion in Medicaid will affect participation rates during the mid-nineties. To ensure consistency with the Administration's Budget estimates, the Health Care Financing Administration's projections for persons insured by Medicaid are used to estimate targets in the extrapolation of these items in the ITM.

Tax Calculator: Using the extrapolated files, the tax laws for each year in the Budget period are simulated. In combination, these simulation programs are referred to as the "tax calculator" or simply, the "calculator." The calculator takes information from each potential tax filing unit in the data file, and using a set of specified tax parameters, computes that unit's Federal individual income tax liability under the proposed change in law.

Two basic revenue estimating assumptions are embedded in the calculator for computing tax liabilities. First, all filers are assumed to choose tax options which minimize their tax liabilities. Second, variables such as the level and distribution of total pre-tax income or total expenditures are held constant when simulating a tax policy change.

The calculator computes the values of a number of variables that are endogenous to the

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[4] At the time of the release of the Administration's health reform plan, the estimates were based on the Administration's economic assumptions contained in the 1993 mid-session review. The economic assumptions were extended through the year 2000 by OMB for purposes of determining the longer-term budgetary impact of health reform.

model -- that is, these are tax variables, in addition to liabilities, which may be affected by a proposal and which, in turn, can affect the calculation of tax liabilities. In general, the ITM can trace through most of the interactions between any income source and the various provisions of the Internal Revenue Code.

Appropriate behavioral responses have been incorporated into the tax model. In addition, as will be discussed further below, off-model adjustments are often made by the analysts to incorporate other anticipated behavioral changes in response to a proposed tax change.

Uses and Limitations of Model Output

As noted above, the ITM is a powerful tool which enables OTA economists to better analyze the effects of various proposals. There are several important distinctions, however, between the output of the tax model and the final analyses prepared by OTA.

First, even in the simplest case, output from the ITM does not go unexamined. Output is subject to a reality check. Users of the ITM check carefully the results to determine if they appear reasonable. For example, users may compare the extrapolation of a particular variable with data which has become available since the initial construction of the tax model. Such information may include data from more recent samples of tax returns (e.g., the 1991 SOI sample of tax returns), other government organizations (e.g., the Bureau of Labor Statistics' Surveys of Employee Benefits; the Census Department's Survey of Income and Program Participation), trade associations (e.g., surveys conducted by the Health Insurance Association of America), and independent consulting organizations.

Second, the ITM is best utilized to analyze the effects of changes in the tax code that affect broad groups of taxpayers and involve current law tax rules. The tax model cannot be relied upon exclusively to estimate changes in the tax code which affect narrow populations or introduce new income tax rules. In these instances, OTA economists may rely on "spreadsheet" models to produce estimates of tax changes. Often, these spreadsheet models are, themselves, quite extensive and sophisticated. In many cases, information from the ITM (e.g., the marginal tax rate faced by a comparable group of taxpayers) may be used as input into these spreadsheet models. The ITM is also not used to analyze proposals affecting tax units other than individuals. For these purposes, OTA maintains several other tax models, including a corporate model, a depreciation model, and an estate model.

Third, subject to certain budget estimating conventions, estimates of the revenue effects of tax changes include assumptions about changes in taxpayers' behavior induced by changes in tax policy. Given the set of macroeconomic assumptions used to prepare the Budget, major GDP components -- such as real and nominal GDP -- are assumed to be fixed for purposes of estimating the deficit impact of a proposed change in legislation. Thus, for revenue estimates, behavioral effects are constrained by this "fixed GDP" assumption. Behavioral assumptions which affect the composition of GDP, but not its level, are integral to the revenue estimates.

- Employees' ability to negotiate with employers to obtain tax-preferred methods of paying for supplemental coverage and the employee share of the cost of the comprehensive benefit plans.

The data sources and the key underlying assumptions for each of these items are described briefly below.

Costs of the Benefit Package: The Health Care Financing Administration (HCFA) provided estimates of the costs of the benefit package at 1994 levels, assuming that the plan was fully effective in that year. Their estimates included the effects of moving to a system of universal coverage.

Rate of Growth in the Costs of the Benefit Package: All agencies involved in estimating the budgetary impact of the health reform plan used the same assumptions regarding the rate of growth in the cost of the benefit package. Under these assumptions, the basic benefit package was assumed to grow at a rate consistent with private health insurance between 1994 and 1996. Beginning in 1996, the costs of the plan were assumed to grow at the targeted rates of growth specified in the health reform plan (CPI+1.5 percentage points in 1996, CPI+1.0 percentage points in 1997, CPI+0.5 percentage points in 1998, and CPI in 1999 and 2000). These rates of growth are based on the assumption that the cost containment initiatives contained in the plan are effective.

Premium Discounts: Under the plan, premium discounts are provided to ease the burden for some employers. First, small firms with fewer than 75 employees and average wages below $24,000 will be entitled to significant premium discounts. Second, the Federal government will provide premium discounts for other firms within the regional alliance if the cost of providing the comprehensive benefit package exceeds 7.9 percent of their payroll. Some employers will receive premium discounts even though they provided health insurance in the past. These employers are expected to pass the discounts back to workers in the form of higher wages and other benefits. Receipt of premium discounts, then, could affect the estimates of the plan on Federal receipts.

HCFA is responsible for producing the official estimates of the costs of the premium discounts. Using Treasury's Individual Tax Model, it is also possible to simulate the receipt of the premium discounts by individuals (as passed back to them by their employers). Treasury's estimates of the premium discounts were used solely as an input into the analysis of the effect of the plan on Federal receipts. As a check, OTA's estimates of the premium discounts are reconciled to those produced by HCFA.

Demand for Supplemental Coverage: Workers' demand for supplemental coverage is estimated largely as a function of expenditures on medical services for items not within the scope of the comprehensive benefit package. Data on reimbursable expenditures on health insurance, as well as current health insurance expenditures, are used to determine the value of supplemental health insurance coverage. Estimates of the costs of administering health insurance (the "load

factor") under the current system were provided by HCFA. The estimates also account for changes in the price and demand for supplemental coverage following health reform.

Cafeteria Plans and Other Tax-Preferred Arrangements with Employers: Under the Administration's health plan, individuals may be responsible for a portion of the cost of the comprehensive benefit package. They may be liable for the difference between the cost of the plan which they select and eighty percent of the weighted average cost of a plan within their region. As under current law, workers are generally required to pay for health insurance premiums out of after-tax income. However, the current system provides workers with several opportunities to reduce their health insurance costs by paying with pre-tax dollars. To the extent that workers can take advantage of these options, tax receipts will fall.[10]

The estimates of the required employer contribution (with premium discounts and cost containment) took into account the likelihood that individuals may seek ways to shelter, on net, more of their health insurance premiums through cafeteria plans and other informal arrangements with employers. The estimates also took into account other offsetting factors (such as some reductions in contributions which, under the current system, cover out-of-pocket reimbursements).

Estimating the Effect of Restricting Contributions for Health Insurance

Under the plan, employer contributions for the comprehensive (i.e., standard) benefit package (up to 100 percent of the costs of the package) would be excluded from income for purposes of calculating individual income and employment taxes. Employer-paid premiums on supplemental plans would now be included in employees' taxable income.

While this provision would generally become effective January 1, 2004, contributions for health benefits through cafeteria plans would be disallowed, effective January 1, 1997. As a consequence, the seven-year estimates of the revenue impact of health reform only show the impact of the restrictions on employer contributions through cafeteria plans.

OTA's estimates of the effects of the restrictions on cafeteria plans are "stacked" after the combined effects of the required employer contribution, cost containment, and subsidies have been taken into account. In other words, the baseline for cafeteria plans, in these estimates, assume that individuals have already made certain adjustments to other aspects of health reform. Thus, for example, the baseline would reflect changes in the utilization of the cafeteria plans in response to the required employer contribution.

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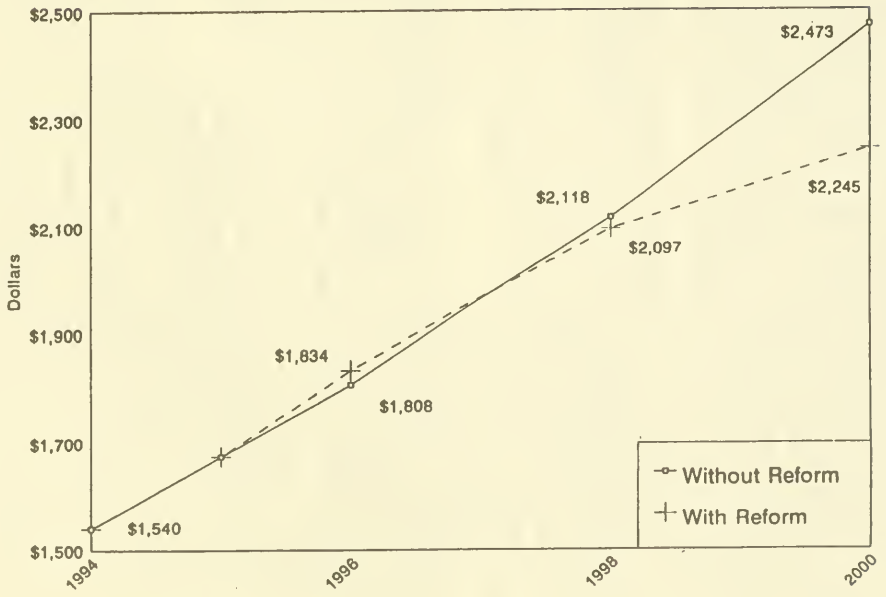
[10] As will be discussed further below, the Administration's plan would restrict contributions to cafeteria plans. The estimates of the effects of the required employer contribution do not reflect these proposed restrictions. The effects of these restrictions are estimated separately, under the assumption that employee behavior has changed in the ways described in this section.

When contributions to cafeteria plans are restricted, individuals may have alternative opportunities to shelter income through other tax-preferred arrangements with their employers (e.g., the employer may agree to pay the full amount of the employee contribution and, in turn, explicitly reduce wages by an offsetting amount). These alternatives for sheltering income are taken into account in the revenue estimates for restricting cafeteria plans.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-C

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN T. MYERS TO JAMES B. KING

Question 1. Director King, in a September 14, 1993, press release, you announced a three-percent (3%) increase in the overall cost of premiums for the Federal Employees Health Benefits Program [FEHBP] in 1994. This is less than the current inflation rate and substantially below the health care services inflation rate. FEHBP coverage already incorporates the key elements of the President's proposal such as guaranteed coverage regardless of health status, choice of coverage level, and the absence of preexisting condition limitations. Would you explain the reasons why you would disband the FEHBP despite its proven track record in holding down health care costs and providing quality care to Federal employees and annuitants?

Answer. While the FEHB Program offers a working model of many key elements of the President's proposed Health Security Act (HSA), the reformed national health system would result in significant improvements for the FEHB population. For example:

The reform would extend the security of affordable health insurance to all Federal employees by providing premium discounts for lower-income workers and equal access to employer-supported health insurance for permanent and temporary workers. Furthermore, Federal employees and their families, like other Americans, would no longer need to fear becoming uninsured since alliance eligibility would not terminate due to changes in employment or family status.

Federal enrollees would continue to enjoy essentially the same comprehensive health care benefits the FEHB Program now offers, but the Government premium contribution would increase to 80 percent of the average premium, compared to the current 72 percent FEHB contribution.

Moreover, the HSA would result in lower future premium increases for regional alliance health plans. OPM's long-term success with FEHBP cost-containment is less dramatic than the modest 1994 average premium increase would indicate. Over the last 10 years, annual changes in the FEHBP average premium have fluctuated from an annual decrease of 11 percent in 1986 to an increase of 25 percent in 1988. On average, increases have been equivalent to about 11 percent over that period; typically, we run about 3 percentage points below the national trend in health insurance inflation.

Standardization of benefits, cost-sharing arrangements, and consumer information requirements for all regional alliance health plans would make plan comparison and informed choice easier. Individual health security cards for accessing services and uniform billing and claim processing systems would result in an administratively simpler and more efficient system for enrollees to deal with.

Other factors to consider include OPM's statutory obligation to contract with private insurers to provide FEHB plans and the unlikelihood that these carriers would be interested in conducting one program exclusively for FEHB enrollees and another for the rest of their business. Also, as was clearly demonstrated by recent laws extending Social Security Act coverage to Federal employment, the public does not want Federal employees to be exempted from programs that apply to the rest of the population. Finally, if they participate in the same health care program as other Americans, Federal employees will not be vulnerable to changes directed specifically toward them because of policy or budgetary decisions unrelated to their health care.

Question 2a. A number of Federal agencies such as the FDIC currently have independent health plans. Will any Federal agencies other than the Postal Service have the option of creating corporate alliances?

Answer. The legislation expressly defines the Postal Service as a corporation eligible to establish a corporate alliance (Sec. 1311(e)(2)). No other federal agency is so designated.

Question 2b. Won't the Federal Government be the only large multistate employer that lacks the option of creating a corporate alliance?

Answer. So far as we know, the Federal Government would be the only large (more than 5,000 FTEs) multistate employer denied the corporate alliance option.

Question 3. Director King, you worked to convince the White House to keep the FEHBP intact until all regional alliances have been established. I am concerned that the American Health Security Act would terminate the FEHBP on December 31, 1997, regardless of whether the January 1, 1998, full implementation date has slipped. This provision seems unnecessarily inflexible. Some have suggested that we should replace a proven product—the Federal Employees Health Benefits Program—with a proven product. Have you considered making the FEHBP termination date either December 31, 1997, or December 31 of the year in which all the regional alliances have become operational?

Answer. Under the proposed legislation, these effective dates are one and the same. In the absence of a State system, the Secretary of HHS is charged with taking the necessary steps, including establishment of regional alliances, to ensure that the comprehensive benefits package is provided to eligibles in the State. Therefore, the legislation assumes that either a State system or a system administered by the Secretary of HHS will be in place in every State by January 1, 1998.

Question 4a. Director King, in the event the FEHBP is disbanded, over three million Federal employees wills be required to positively reenroll in the Regional Healths Alliances to which their coverage is transferred. In 1989, when AETNA withdrew from the FEHBP, over 15 percent of its enrollees failed to positively reenroll in other FEHB plans even though OPM sent them four Certified Letters reminding them their obligation to do so. If past experience is any guide, won't the positive reenrollment requirement of the President's reform proposal cause many Federal and postal employees and annuitants—particularly those elderly annuitants without medicare coverage—to receive default coverage into the lowest cost plan in the regional alliance?

Answer. Alliance-eligible Federal employees and annuitants who fail to enroll in an applicable alliance health plan will be provided necessary information and a 30-day opportunity to choose a health plan when they seek health services for the first time after FEHBP expires. They will have the full choice of health plans offered in their area (they will not automatically be enrolled in the lowest cost plan). Then, if the individual fails to act, the alliance would effect enrollment in a plan selected on a random basis.

Question 4b. Does your legislation penalize such people by charging them twice the regular premium for the entire year unless they can show good cause for failing to make a timely election?

Answer. There are penalties for persons who fail to enroll in a health plan, absent good cause. Individuals who do not enroll during open season (or when they move to a new alliance area) will become enrolled when they seek health care services, as noted above. Persons who fail to enroll, as required by law, will be liable to the alliance for twice the amount of the family share of premium (i.e., not the entire premium) that would have been paid had they enrolled on a timely basis.

Question 4c. Would not it make more sense to permit Federal employees and annuitants to follow their plan into the regional alliance assuming that the plan is accepted for participation in the alliance?

Answer. Your proposal to permit FEHBP enrollees to automatically transfer with their current health plans to the regional alliance system could simply the transition for FEHBP enrollees who either are content with their current health plan or who might fail to enroll in an applicable alliance plan for any other reason. But, as you recognize, some existing FEHBP plans might not successfully apply to join an alliance. In addition, we must determine if such an approach would be destabilizing in any way to plan competition in particular alliances. A large FEHBP plan could have an enormous advantage in the alliance bidding process due to a high retention rate through passive enrollments and, in turn, a known risk pool for rating purposes. We will continue to look at this.

Question 5. The Clinton proposal allows large corporate entities to create their own health alliances. It is expected the postal service will choose such an option. How much will a corporate entity be charge for opting out of the geographical alliances envisioned under you plan? What effect on the Postal Service will this charge have?

Answer. The charge to which you refer will be imposed in order to ensure that employers that form corporate alliances contribute toward the financing of graduate medical education, academic health centers, and related activities intended to benefit individuals and employers, as well as the costs of providing universal coverage. The Health Security Act provides for an annual assessment equal to one percent of the employer's payroll. Payroll generally includes all FICA wages paid by the employer. Since some Postal employees are covered by the CSRS retirement system and are not included under FICA, while others are covered under the FERS system and are included under FICA, it is not clear at this time how the tax base would be determined if the Postal Service opts to establish a corporate alliance.

Question 6. Current FEHBP Policy encourages enrollees and their families to use preferred provider organizations when enrolled in a fee-for-service plan. How will PPO's fit into this new scheme? Will the standard benefit package you describe be as generous as a fee-for-service plan with a PPO option?

Answer. The HSA provides for a combined plan that is virtually identical to a fee-for-service plan with a PPO under the FEHBP. Under the combined plan, when an enrollee uses network providers the low cost sharing provisions apply, and when an enrollee uses out-of-network providers, the high cost sharing provisions apply. Actu-

ally, for in-network services, the HSA cost sharing provisions are somewhat more generous than currently offered by in-network services under FEHBP fee-for-service plans.

Question 7. There has been talk that employers providing a more generous benefit package than that provided under your plan will see such additional benefits taxed in order to pay for reform. Will federal or postal employees be affected by such new taxation?

Answer. Under section 7201, employer-provided Medigap policies for former employees age 65 and above and supplemental policies related to the cost sharing aspect of the HSA benefits package would remain tax-exempt for employees, including Federal and Postal employees. Moreover, any employer contribution to other supplemental health plans would not be taxable to the enrollee until after 2003.

Question 8. Administration officials have testified that anywhere from 30-40 percent of Americans will pay more for Health Insurance under the Clinton Proposal. Where do Federal and Postal employees fit into this scheme—will they be paying more? If so, will the benefits package be more generous than the one they enjoy now?

Answer. Individuals who may expect to pay more for health insurance under the reformed system are basically young, healthy, usually single, persons who presently are able to buy low-risk policies or who forego insurance altogether and individuals who buy catastrophic coverage which delays benefits until medical expenses surpass a high deductible amount. Federal enrollees will be better off overall under the President's program. They will still have a comprehensive benefits package comparable to the best FEHBP plans now available and they will generally receive a more generous employer contribution-80 percent of average insurance premium versus the current 72 percent average premium contribution under FEHBP. Also, they will see future health care costs grow at a slower rate as a result of efficiencies under the reformed medical and legal systems and will have the security of guaranteed coverage at all times.

Question 9. I understand that OPM may be allowed the discretion to offer supplemental benefit packages to current employees to fill for any gaps in coverage of the Clinton Proposal. Would you please describe for the committee how this will work, under what circumstances a supplemental plan may be offered, to whom it will be offered, and where the funding for such coverage will be located?

Answer. The President's proposal (HSA) requires OPM to offer Federal employees one or more supplemental insurance plans which, at a minimum, are consistent with other applicable HSA provisions and fill any gaps between coverage under the proposal and benefits generally afforded under the FEHBP, as last in effect. While the proposal does not mandate a Government contribution for such plans, it does not preclude this. Thus, OPM would have broad discretion to determine future benefits policy in this area to enable the Government to maintain competitiveness with other employers and could seek appropriations authority for Government contributions if deemed appropriate.

Mr. CLAY. Thank you.

Let me say that I think the first and foremost question on the minds of committee members as well as many of the Federal workers is: Why abolish the FEHBP? Your statement, Mr. King, focused more on what will happen to Federal employees, rather than why.

And before you respond to the question, let me say that those of us on this committee genuinely support the President's effort. We want to see health reform and we want this President to succeed.

Yet, the administration is proposing to abolish a sure thing: a program that works, a program that serves 9 million people, a program that, with very few changes, would be a model of managed competition.

And in its place, we see that a system would be put that is brand new and relatively untested. At the same time, the President would leave intact much of the veterans and military health care systems and would give other large employers the option of running their own health benefits plan.

My question is: What are the administration's very best arguments for abolishing the FEHBP and not treating it as a large employer?

Mr. KING. Well, I realize FEHBP is being abolished, but for those of us who have been working with it on a regular basis, Mr. Chairman, we see this as a transfer.

Our particular operation seems to be the model, if you will, of what the President's plan is. To be very candid, Mr. Chairman, as you look at it—and I know you have—it's striking in the similarities. And that's why I suggested that it's almost a seamless garment in the transfer aspects.

Doctor, you do business every day in the medical arena. How does this comparison strike?

Dr. FEDER. I think that was exactly the intent as we developed the plan in the course of the working groups in consideration of the development of a system.

There was a strong desire to move all Americans into a common system. And in developing that system, we drew very heavily on the experience of the Federal employees program because it is an effective model, although I think, as you and others indicated, it, too, could have improvements. And in building on that model, we feel that we are strengthening protections for Federal employees. And let me indicate some of the ways.

First, all Federal employees will now have security of coverage, whether they stay in their Federal jobs or go somewhere else. Essentially, they have the opportunity to stay in the same plan, to have affordability of coverage that not only they, but millions of Americans, are now lacking.

They will have the security of knowing that their children as they age out, as we say, of their parents' plans as they grow up and may not have coverage themselves will also have security of coverage that they and their families will, like all Americans, have health care that is always there.

The benefits that they are guaranteed are comprehensive benefits, the package is roughly equivalent to the package that the—the guaranteed package is roughly actuarially equivalent to the package they have now. The benefits are in some sense stronger, in some sense a little less, but essentially it is a comprehensive package, like that with which they are familiar.

They will continue to have an opportunity for choosing plans. In many respects, it will be a clearer choice. One of the historic issues in the Federal employees program has been that there are differences in plans, leading to selection problems in different plans. That's been a continuing problem. That will no longer be the case in the President's health security plan since all plans offer the guaranteed package.

Furthermore, in integrating and in building upon the Federal employees program. It was our objective in using this program as a model to bring other Americans up to the standard that Federal employees have come to expect and, by integrating all Americans into that same system, essentially to secure protection for Federal employees, rather than as, unfortunately, it was the case over the last decade, having those employees stand out as sometimes a target for attack as having better protection than others. It is our

view that having all of us in the same boat will strengthen protection for all of us.

Mr. KING. Mr. Chairman, if I could just add to that?

Mr. CLAY. Certainly.

Mr. KING. I think you had a very thoughtful and excellent report drafted for the committee, which indicated that over the years the Federal employees have had as little as 24 percent of the premium payments for our health insurance paid for by our employer, the Government. It's been increased now up to 72 percent, but will be going to 80 percent under the President's plan—that, at least, is the minimum guarantee.

So I'm suggesting that on actual preminums, there's an enormous kind of wave that we've been subject to as employees. So I wouldn't want to suggest on the historic view—as you're well aware, Mr. Chairman, in large part, I think we're held to whatever standard others would like, rather than a national standard.

And there are times where committees like this have been extraordinarily generous and sensitive, generous in the sense of spirit, Mr. Chairman, not necessarily that you've met every aspiration. And that is not accusatory; that is a voice of gratitude.

I also think that we should stress that what we've done is preserved choice. The real plan that's in the President's proposal gives a very striking range of choices. The choices are very similar to what the Federal employees presently have—HMO's, fee for service plans, and provider networks.

The only difference is that program administration would be moved to regional alliances, and we would be offering the options under them, rather than the present system. That is a bureaucratic issue. It does not necessarily affect the quality of the service to the individual.

It enhances our security, I think as pointed out so effectively by the Doctor. What we do is provide a context where Federal employees don't stand alone. I'll take myself as an example.

I have adult children. My adult children are among those who have fallen through the cracks in the present medical care system. At least two of them don't have health insurance care at this moment. One of them is an older student in graduate school. The other one is an older student in undergraduate school, Mr. Chairman.

They have no health care coverage whatsoever, and they're at risk every moment of the day because of that. And it really puts us all in jeopardy because we are a family and we care about each other. Or, another example, my brother-in-law left Federal service and died of cancer. Because he had used his wife's health program earlier, he ended his service before he completed his fifth continuous year in FEHBP which is necessary to continue coverage after retirement, and he was basically abandoned at the time when he needed health care insurance the most.

Those gaps won't occur. There won't be any people like I'm discussing in my own family and which any Federal employee can discuss in the context of their own family.

Mr. CLAY. Fine. Dr. Feder, if we're all going to be in the same boat, that's one thing, but we aren't all in the same boat. And if this is going to be such a great plan for Federal employees, why

did you leave the postal employees out? Are they not Federal employees.

Mr. KING. I believe that their organization is, first of all, in transition, Mr. Chairman, into being identified as a private sector corporation and operating as a private corporation. They have extraordinarily sound and effective bargaining units. Those bargaining units——

Mr. CLAY. Who informed you of that? They're in what transition?

Mr. KING. Which, sir?

Mr. CLAY. The postal employees.

Mr. KING. It was my understanding—and I certainly would stand to be corrected by the Chair—that the Postal Service was converted over to a quasi-public entity which would increasingly operate like a private sector entity, back in the early 1970's—and I know because I used to work in the Patronage Office of one of the folks.

It was run more like a private business than anyone had ever seen before in the Postal Service. And with bargaining units bargaining for both wages and benefits, it becomes more in the context, I understand, of a private sector operation.

Mr. CLAY. May I ask you, Dr. Feder: Have you talked to anybody at the Postal Service that has indicated any interest in establishing a corporate alliance?

Dr. FEDER. I've had several discussions over the course of this process. I don't recall a specific—I have had some conversations with people involved in the Postal Service who had that interest, yes.

Mr. CLAY. Have you talked to anybody in the top management of the Postal Service who has said to you "We want to set up a corporate alliance"?

Dr. FEDER. No, no, not to my recollection.

Mr. CLAY. Let me ask you this: For months we have heard that you want to treat Federal employees the way you're suggesting for political reasons, that you don't want the impression to be that Members of Congress and congressional staff are receiving better treatment than the average American citizen. Is that correct? Let me quote from the Washington Post, and I'll ask you to comment on it——

Dr. FEDER. All right.

Mr. CLAY [continuing]. Because it's precisely what we have heard for months. The Washington Post says, and I quote, "Originally White House sources said FEHBP would be dismantled because the administration did not want the public to think that civil servants, members of Congress, and congressional staff were receiving special treatment or that the Clinton health plan was not good enough for them." Will you comment on that?

Dr. FEDER. I'd be happy to. As I think I indicated in my earlier answer, I would state that differently. What I think is if you look at the experience over the last decade, the way in which Federal employees have in many respects been a target for concern is standing out in terms of their benefits and their salaries, it is a judgment that we have made that we would be in a stronger position if, as I said, other Americans got the protection that we got and essentially took us off the bull's eye. And that is the way we have perceived that issue.

Mr. CLAY. So that is a political decision you made. It had nothing to do with the merits or whether or not what was best for the Federal employee was the present system with a few modifications.

What I'm saying to you, and what I think every member of this committee wants to say to you, is that if you don't bring the rest of the country up to the level of coverage offered in the FEHBP, then we shouldn't join a program that provides less benefits and is more costly than what we're already offering to them.

My recommendation to you is that we don't even talk about joining until you bring the health coverage for the rest of the American public up to where we are now. That should be our goal, and that's the model that you ought to be pursuing.

Dr. FEDER. Mr. Chairman, we think that that is precisely the model that we are pursuing, if I may elaborate for a moment. I think that what you just said and what you said in your introductory remarks about it being unacceptable to—I'm paraphrasing—eliminate the Federal employees program unless Federal employees had secure protection on a par with what we have today and are indeed better off, I would share your concern and would agree that you're, if I may, taking an appropriate position. What we believe——

Mr. CLAY. You will support an amendment that this committee will offer to assure exactly what you just said?

Dr. FEDER. What I believe is that in terms of our OR proposal, we are providing Federal employees that protection, that the security is strong, that they are receiving better protection in many respects than they have today, and that they will be better off as a result of this proposal and indeed——

Mr. CLAY. So my question to you is: If they are not at the end of this cycle, will you support an amendment by this committee that we don't go into that?

Dr. FEDER. We are committed to having all Americans brought to a level of protection, as indicated in the plan. And that's what we support and will continue to work with you to see that Federal employees are protected, as they should be.

Mr. MYERS. Mr. Chairman.

Mr. CLAY. Mr. Myers. We've got to move on. Mr. Myers.

Mr. MYERS. Well, thank you, Mr. Chairman. I share the Chairman's concern about the direction that we seem to be taking.

OPM has made certain recommendations here. Was this your decision to make the direction that you've taken, giving the right for the postal corporation to exempt itself or to create its own alliance? Were you told to do that or was this your decision to bring all of the federal employees and to drop FEHBP and all of these others? Is this your decision or are you just carrying out the wishes of someone else?

Mr. KING. Let me ask you to maybe put the question in context. Do I have any difficulty or reservation with the Postal Service being set up the way it is being set up?

The answer to that is "No". It's done on the basis of strong bargaining units, and it's moving in the direction of a private corporation. It's acting like a private corporation.

It's quacking. It's waddling. It's swimming. And the webbing is forming between its little toes. I think it's moving toward being that collective duck. We in the Federal service are not.

Mr. MYERS. Then it's OPM's decision of what you are recommending in your statement here? What? His analogy here. I'm not sure about the ugly duckling. It is kind of ugly, but——

Mr. KING. That's me, sir. I'm the duckling.

Mr. MYERS. I kind of agree with you. This is kind of an ugly situation we find ourselves in. Your recommendations here if they are—that's what I'm trying to find out, if this is OPM's decision to go in this direction or did OMB or somebody else make this decision or someone at the White House make this decision for you?

Mr. KING. We worked on the teams, the initial teams. We sent forward our professional people to work with the White House when they were developing this program.

The mandate to those professionals—and the head of that unit is sitting on my right, Curt Smith—my mandate to Mr. Smith and the team when they went forward—Mr. Smith, I think I'm correct when I say this now—I said to them that I wanted them to act as advocates for two separate groups. One was the retirees. I felt that I had a trustee relationship in relation to the retirees as a whole and that we would act as trustees in that situation.

For the active Federal employees working under the agreements that we presently had on health care, I advised Mr. Smith that he would act and the team would act as advocates, using our program as the model and the statistical data available on the million-plus people involved, and give all possible assistance in helping to shape the President's plan so you didn't have to make up, if you would, models to look at, economic or otherwise, that didn't have a real touch with reality. I thought we were a good base for that.

And I believe, Mr. Smith, that is how it was.

Mr. SMITH. Yes, that's pretty much how it has gone. And I think it's fair to say about all of the things that we're talking about today, that these are presidential and administration decisions which must be judged in the context of the total health security plan and not by pieces of that structure.

Mr. MYERS. Well, the thing that disturbs me is, as an example here, you've exempted or at least given permission to the Postal Service to exempt itself and create its own—I guess its own alliance.

And you haven't discussed this with the Postmaster General, I understand. How did you——

Mr. KING. No, no. The bargaining units have negotiated existing programs. The Postal Service has got some very sophisticated unions.

Mr. MYERS. There are a lot of agreements——

Mr. KING. No, no. These are employee-based.

Mr. MYERS [continuing]. Among other agencies. Other agencies, are they going to be——

Mr. KING. These are employee-based programs. That's why, by the way, the discussion about what will be under the national or the private, they're virtually identical. The same kinds of programs come forward.

You as a Federal employee pick and choose. The principal difference will be that the information you get to make that decision will be better. You can make a better choice, a more informed choice than you can right now.

Mr. MYERS. That's the whole thing. It seemed to me like dragging all of these Federal employees and the very fine programs they have into this alliance all over the country, they're going to be very difficult to administer.

Right here in the District of Columbia I'm sure, Mrs. Norton—I'm not going to get into your area—you've got some concerns about the alliances. I live on the Illinois–Indiana border. We have people working in one State and living in a different State, back and forth.

I see all kinds of problems. But the Federal employees right now we're concerned about.

Mr. KING. Right.

Mr. MYERS. And it seems to me like you're going to drag the Federal employees' programs down, probably costing more money because they're going to be thrown into an alliance someplace with maybe a high-cost area, when today individually they're not paying as much and have got better programs than you're going to bring to them. And it doesn't seem to me like there's any need for it. If it ain't broke, don't fix it.

And I just don't understand why you had to bring these people in when they have an existing program right now that's been working very fine. And, as far as I know, almost every Federal employee is pleased. Every one of them has a chance to change periodically.

It's been a good program. And I don't know why in the world you're dragging them into this thing. I don't disagree there are some in the country who need better programs, but is this the way to do it?

Mr. CLAY. Mr. Ackerman.

Mr. MYERS. I have a series of questions I will, Mr. Chairman, ask that——

Mr. CLAY. Yes. We will submit written questions.

Mr. KING. We'll respond for the record, Mr. Chairman.

Mr. CLAY. Mr. Ackerman.

Mr. ACKERMAN. Yes. Thank you very much, Mr. Chairman. Thanks for the opportunity to participate.

Let me welcome our witnesses and tell you how pleased I am to see that the administration has taken so much from our Federal Employees Health Benefits Program to fashion into your program. The problem is you didn't take enough.

We have worked long and hard on fashioning something called the Federal Employees Health Benefit Act of 1993, which is H.R. 45, which is a basic reform of the committee. We did that when I chaired the Subcommittee on Compensation and Employee Benefits.

We're happy to see that you have come to the conclusion, after so much study and work and so many person-hours, that we do have a terrific plan.

We have a political problem here, and we also have a mechanical problem in fashioning this legislation. The President had said that he was going to look to take the best of everything that we had and eliminate those things that were bad. What you've done here is

you've eliminated the bath water. You've also thrown out the baby. And now you're trying to toss the bathtub after it. It's just not going to work.

If indeed with regard to Federal employees the transition is going to be seamless, as were your words, that you're hardly going to notice the transition, then why not take everybody in America and put them in a Federal employees' type health benefits program, do the transition the other way?

We wouldn't have the problem politically if you were looking at the situation and saying "Gee, we can't vote for that because we're going to exempt ourselves. You have to include us in. Otherwise, we're treated as special."

If you look at this from a sales point of view, as I would like to look at it in promoting this to the American people, I would sell it the opposite way. I would say "We're going to put you in the same health plan that your Congressperson has." That seems to be an easier sell.

Mr. KING. But that's what we're doing. In point of fact, you've just——

Mr. ACKERMAN. No, no, no, no, no. That's——

Mr. KING. The administrator——

Mr. ACKERMAN. That's like having a proctologist look down your throat. [Laughter.]

Mr. KING. I will pass up the opportunity, Mr. Chairman.

Mr. ACKERMAN. We can pass on a lot of things, but, nonetheless, it's a matter of the sense of direction that you're taking.

The other problem that I see—and I'm going to have to go and vote, much as I would love to stay. The other problem, as I see it, is you then propose to make Federal employees whole by giving them a supplemental package of benefits to bring them up to something comparable.

Well, if there's not enough benefits in the package for the American people, how can we tell them that we're going to be in it, but we've got to do something better for ourselves on top of that? That creates a political nightmare for elected representatives and a strategical problem, I would think, for promoting this.

Dr. FEDER. Mr. Ackerman, may I respond? Do you have time or do you want me to wait?

Mr. ACKERMAN. No. Go ahead.

Dr. FEDER. Oh, OK. I wanted to say, first of all, that it is essentially—we do think, despite the sense of direction example you gave, that we are bringing all Americans into a Federal employee-like program.

The reason that we don't move directly to bring them into that program has to do with the President's overall philosophy for reform, which is that we want a State- and community-based system when it comes to health care.

Mr. ACKERMAN. You can do that with modifications of this plan. Look at this plan, if you will, as a Federal employees' HIPC.

Dr. FEDER. But, again, what I'm——

Mr. ACKERMAN. The Federal Government has employees in many States, the same as General Electric or some other major companies you might be willing to exclude. Don't look for the lowest com-

mon denominator. Don't bring the good down to find an average somewhere. Let's elevate everybody up to——

Mr. KING. That's not an accurate reflection of the facts as we've reviewed them, to be very candid. And, as a matter of fact, we're going to be able to include about 300,000 more people who are presently on the Federal payroll who either can't participate for economic reasons or can't because of the type of job they hold when they're in the Federal Government.

Mr. ACKERMAN. I would respectfully suggest that you take a look at the possibility of setting up a Federal employees' HIPC and have it out there with the rest of the HIPC's that are out there. And perhaps when we see better HIPC's and worse HIPC's, we can pick and choose and emulate the better ones and aspire to take the good from them and eliminate. I mean, it's a possibility that you should consider very strongly.

Dr. FEDER. I hear your concern. Of course, we would continue to work with you. But, if I may, let me clarify. Essentially what we're doing in terms of the cooperative is establishing one that is community-based. It applies to that entire community. And it is in that sense that we are talking about building on a local market and creating a true community in which health plans can develop and across which we share risks.

That is a State- and local-based program that is somewhat different from the model that you put forward.

Mr. ACKERMAN. The model that we put forward had to do only with Federal employees and doesn't cover the 39-or-so million people. But that can all be accommodated if you allowed this to be HIPC.

But let me get on to something else because I've only got a minute to rush over. I understand that Secretary Bentsen has testified that tax revenues in America are going to increase as a result of the implementation of the President's health plan because people will have wage increases because that's going to supplant the contributions that employers had to make to health coverage. Is that going to occur in the Federal sector, too?

Dr. FEDER. There are Federal savings as well. I'm not sure that they——

Mr. ACKERMAN. Yes. Is that going to accrue to the benefit of Federal employees? The money that you save off the backs of the Federal employees by switching them into a different health plan, in the private sector, they're going to get increased wages. They're going to get taxes from them. Are you going to increase the wage base of Federal employees so the package stays the same so the Government can get those increased revenues?

Mr. KING. I don't see any link between what you've just said, sir.

Mr. ACKERMAN. Pardon?

Mr. KING. We don't see any link to that observation.

Mr. ACKERMAN. You don't see a link?

Mr. KING. There isn't a link. There's nothing on the backs of anyone. The employees——

Mr. ACKERMAN. Well, let me take out the editorial language.

Mr. KING. Sir, the employees get the same program choices. It's who finances them. I don't think the average Federal employee is——

Mr. ACKERMAN. Yes, but the Federal Government is saying——

Mr. KING. No, but we're——

Mr. ACKERMAN [continuing]. Because people in the private sector are going to have this shift to a——

Mr. KING. To our type of program, sir.

Mr. ACKERMAN. To your type of program that——

Dr. FEDER. The question——

Mr. ACKERMAN. The wage package that the worker receives will be increased because——

Mr. KING. Ours. We'll get a greater one. We'll go from 72 to 80 percent——

Mr. ACKERMAN. No. I'm talking about the private sector.

Mr. KING. We'll get an——

Mr. ACKERMAN. In the private sector, Secretary Bentsen is saying that the benefits package given to an employee is going to be the same package, but it's going to shift so the employer is able to shift money from health care to salary. And, therefore, that money will be taxable, and that will be increased revenues.

That's a major selling point. He's saying that the compensation packages of the employees are going to be the same.

Would you be willing to treat Federal workers the same way? If the compensation package is indeed the same in the private sector by making that shift, by saving that money in revenue that Federal employees are getting right now in the form of wages plus benefits in health care and if you're switching and the Federal Government is saving money on the health care, does that money accrue to the benefit of the employees so that we become good, upstanding citizens, like in the private sector, and pay more taxes?

Mr. KING. I think there are two parts. First——

Mr. ACKERMAN. Can I listen on the way out?

Mr. KING. OK. The answer for the record, sir, is that the Health Security Act is going to increase the cost-sharing payment of the Federal Government by 8 percent—from 72 percent of premium to 80 means more. That means that the ordinary Federal employee will be receiving a higher payment or greater value for their dollar. Employers who will spend less on health care, can spend more on wages. But we're talking about a 72- versus 80-percent Government share. And 80 percent is higher than 72.

What I'm saying is that we'd be getting a better break under this proposal—and which bureaucrat pays my health bill is irrelevant.

Mr. ACKERMAN. In the private sector, you're allowing the worker to get a break by shifting benefits in the form of salary over to the—this is unusual.

Mr. KING. It's great. [Laughter.]

Mr. ACKERMAN. I'll submit my questions, Madam Chair.

[Applause.]

Ms. NORTON [presiding]. That indicated great concern and interest. It was not simply a performance. Once again, the District's gain is your loss. Your gain is the District's loss. Your gain is that there are a few matters that I cannot vote on as a Delegate, and conference reports are among them. The loss to the District is I ought to be able to vote on everything. We're third per capita in Federal income taxes paid to the Federal Treasury.

Nevertheless, until the chairman gets back, I will proceed with questions I would have answered in turn. Growing from the question that Mr. Ackerman just left as he swayed out of the room, with good reason on one level, you speak about 80 percent versus 72 percent. Of course, what anybody who has gotten through the sixth grade would say is: Percent of what?

You have not indicated anything about actual premium costs. Therefore, it is perfectly conceivable that this 80 percent wouldn't leave employees in any better position and might leave them in a worse position. Do you concede that at least?

Dr. FEDER. Mrs. Norton, as I indicated earlier, essentially when we've looked nationally at the actuarial value of the package, it is quite similar. And I would like to spend a minute just talking about what the benefits look like.

In the guaranteed benefit package, there is a better catastrophic protection than now exists. The cap on out-of-pocket spending, which I think is a critical element of policies to protect people when they have high expenses, is better in this program than in the Federal employees program. It also includes preventive services without any cost-sharing, another way in which it is a better policy than Federal employees now have.

The differences that exist in the benefit package have to do with the dental benefits, adult dental benefits, and mental health benefits, which are being phased in and will be in the guaranteed package in 2001.

Then there is some difference in some of the cost-sharing structure, but if an individual chooses a low-cost sharing plan, then their expenditures, their prices when they go for service are very similar to those they face in the Federal employees' plan.

So I think it is very important to emphasize that we have a very similar and a very strong package that we are providing Federal employees.

Ms. NORTON. In terms of premiums, though, again, you don't have an indication, enough of an indication, at this perhaps early stage of costs to know what that means to the employee who is paying money now, as opposed to what that employee will be paying then.

Dr. FEDER. Well, what we have, we have a sense nationally of that level. And that's where I talked about the equivalence there. But the issue, an issue, another piece of this, has to do with what the employee's share is out of pocket.

In the Federal employees' plan, an individual must pay at least 25 percent of the premium out of pocket. That's their share of the premium.

Under the President's plan, an individual Federal employee receives their employer contribution, which covers 80 percent of the average plan. If they choose a plan that costs less than average, they will pay less than 20 percent. If they choose a plan that costs average, they will pay 20. And then if they choose one that is more expensive, they would pay more, subject to some overall limits.

So, essentially, the structure of this plan creates options in which employees' share of premiums will be less, significantly less, than what it is under the current arrangement.

You are right, the point about some limited information with respect to actual premium dollars because they will vary in different places across the country. And I cannot give you the specifics on that at this time.

Ms. NORTON. You mentioned catastrophic and preventative features that would improve upon what Federal employees have now. Of course, there's great concern about what the proposal might take from what employees have now with respect to hospitalization, for example.

I would ask you to discuss that, and I would ask you to discuss what percentage of the costs, catastrophic and preventative, are in a typical plan, as you envision it.

Dr. FEDER. Yes, I believe I did. I addressed both sides. I gave the improvements and the—there is a difference in terms of hospitalization.

If an individual chooses what we have called a high cost-sharing plan, then they would pay 20 percent. They would be liable for 20 percent of their hospital bill subject to that out-of-pocket ceiling. And I believe—and Curt will correct me if I'm wrong—today it is a $200 deductible. Is that? $250.

That, as I said, is a difference. However, if an individual chooses a low cost-sharing plan or an HMO or a network plan, then, in fact, their deductible when they go to the hospital would be lower, significantly lower, than what it is today.

Now, you asked also about the costs, the specific elements of the premium costs. That is something that we could provide for you at a later date and I believe may indeed be part of the general presentation we will be providing on our overall cost estimates. But if not, I would be happy to provide that.

Ms. NORTON. Let me ask you as well about supplemental coverage because you have indicated that there would be supplemental coverage here to make up for what employees might otherwise lose. What criterion would OPM use to decide what supplemental plans to offer?

I'd like to know about the projected costs of such supplemental plans as well, additional costs to the Federal Government, additional costs to the employee. Any different from the costs otherwise contemplated?

Mr. KING. We would have to find out and see what the experience is. I think one of the things that we do have before us now under the plan—and that's why I had to open with thanking the committee for their efforts—is it gives us an opportunity to see performance and to do that kind of analysis so that we can give you the correct figures and a correct analysis prior to our transition in 1997. So it would give us that opportunity to see what the experience is on a State-by-State basis.

But at this time, Madam Chair, I would be taking numbers out of the air.

Ms. NORTON. How would supplemental coverage be provided to retirees?

Dr. FEDER. The program essentially guarantees that the current annuitants will be provided supplemental policies that——

Ms. NORTON. Through Medigap or a separate plan?

Dr. FEDER. As appropriate to their circumstances, yes, related to Medigap or otherwise, depending upon their enrollment in Medicare.

Ms. NORTON. Will the supplemental insurance cover excessive premium costs in the event that an alliance's premiums are more than the premiums for insurance plans currently available through FEHBP?

Dr. FEDER. Ms. Norton, in this respect, essentially, we believe that we are making health care more affordable to all Americans. And, essentially, premiums will be constrained as the marketplace develops and constrained by the fail-safe we have in terms of premium caps. And that, we believe, is the appropriate protection in terms of premium costs for Federal employees, as it is for all other Americans.

Mr. KING. As you know, Madam Chair, we have been successful with our program. As you know, it runs about 4 percent below other programs. Part of it is that we have been able to get the cost efficiencies out of size and our ability to negotiate on a plan-by-plan basis.

I think it's really our hope, Doctor, that with a much larger size, those efficiencies should be able to be increased, should they not?

Dr. FEDER. I think there's that. There are other advantages to the new system as well, essentially. Although the Federal employees program has been relatively successful in controlling its cost, its rate of increase is still substantial.

The Federal employees program still bears the cost shift and the burden of paying for those who don't pay for themselves and also from essentially a largely unconstrained system. And so Federal employees, like all other Americans, will benefit in terms of their premiums, from having everybody pay their fair share, eliminating or reducing that cost-shifting, and from slowing the rate of cost growth in the health care system.

Ms. NORTON. On supplementals I would like to know what role you envision for OPM. Is it the agent that is to decide what supplementals will be offered and whether the Government or the employee will pay those supplementals, rather than the individual agency being involved in that decisionmaking?

Mr. KING. To the first question, the answer is "yes". And on the second—we have worked that out, in proposals to the Congress through this committee as part of the package—yes, on the supplementals.

Ms. NORTON. Both of those questions were about the supplementals.

Mr. KING. But the first part, I believe there was a question as to: Are we deciding the policy on them? And the answer was "yes". The second part was: What?

Ms. NORTON. You are the agent.

Mr. KING. Yes.

Ms. NORTON. Individual agencies are not going to be negotiating supplemental amounts——

Mr. KING. No. That's correct.

Ms. NORTON [continuing]. Reinventing government notwithstanding.

Let me ask you questions about the District of Columbia, very troubling questions. These questions are applicable to a number of States, especially States with small populations. I would certainly have a concern with widely varying premiums from one alliance to the other so that Federal employees living in the District, for example, or Montana might be paying significantly different premiums for the same coverage from Federal employees living someplace else. Is that likely to be the case?

Mr. KING. Could we take it in two parts? One is the plan, and the other is what we're hoping to be able to do in relation.

Dr. FEDER. Essentially, it is correct that we will be facing premiums, a variation in health cost, that are locally determined, as those outside the Federal system do today, and that that becomes a part of the national system.

However, we are taking several steps that we believe will dramatically reduce those variations over time. First of all, essentially, the reforms in the system and the cost-containment in the system will dramatically reduce cost-variation across States from what it is today, even as we start.

Second, we have specific mechanisms in the plan to address variations across States, almost as the plan is going into effect. There is a specific provision that calls upon a commission to report to the Congress on a methodology for moving toward greater equity across States. They report, I believe it is in 1995, on a specific methodology to achieve that greater equity by the year 2002.

And so our general view is that by changing the system, we will be achieving greater comparability across States and we take particular steps to move in that direction.

Mr. KING. From our perspective, one of the benefits of having the assessment of the States and their organizational apparatus for establishing their regional payments, and seeing what their performance and what their rates would be prior to the Federal employees being brought into the alliances, is that it gives us an opportunity to identify exactly the kind of thing you've addressed, Madam Chair.

And by that time—and I would like to think that we in OPM have been candid and forthcoming on a number of issues, including this, that affect Federal employees and retirees—we would identify inequities and move toward the programs that might be necessary to deal with them. And that includes any appropriate recommendation based on concerns we share with you.

Ms. NORTON. You mentioned that Federal employees' rates are going up at a slower rate than others, nevertheless are going up and have gone up sharply if you look over time. But the fact is that's a self-contained system at least.

What Federal employees would now go into, as far as you know, could cost the Government significantly more money and could cost you significantly more money because these premiums are likely to be widely out of synch from State to State; for example, in the District of Columbia.

Here you have a very small pool. In fact, Federal employees are a large proportion of the insured population, which have a very small pool. And that pool is not nearly as diverse as it would be if we were talking about New York City, where conceivably to be

joined up with upright of Westchester County perhaps or in the lower part of New York, part of Long Island, in Montana, in small States, and in the District of Columbia, where there's nobody to join up to and the pool is what it is.

How can you be certain——

Mr. KING. Well, let me just——

Ms. NORTON [continuing]. That in such places, premiums will not be wildly out of space compared to premiums where the population is large and the pool is richly diverse?

Dr. FEDER. Ms. Norton, I think that there are issues—and you've raised them several times, as have others—about concern about the nature of the District pool and its specific——

Ms. NORTON. I'm not just talking about the District. There are States where the population—there are States, particularly in the West and in the Southwest, where the population is spread out, sparse, way sparse compared to the most populous State.

Dr. FEDER. Yes, but let me clarify, then, what we do know about the premiums. Certainly our estimates, in which we've spent a great deal of time and drawn on a considerable amount of data, do indicate nationally that there will be savings to the Federal employee system, that nationally the premiums are roughly comparable, that there are—I believe that's correct. I wanted to double check with Curt.

So we do know in terms of when you raised the issue about projecting Federal expenditures and overall savings, we have spent a great deal of time about it and are quite——

Ms. NORTON. Have you looked at the District of Columbia?

Dr. FEDER. Well, now you're asking about variations in localities, and we do not have those specifics——

Ms. NORTON. I'm not just asking about variation in locality. I'm asking about a city that isn't a state, doesn't have a suburban structure, and your bill doesn't say anything about it and I don't have any information about it.

Dr. FEDER. Well, I would disagree. A moment ago you asked me to talk about other States and what I would say about——

Ms. NORTON. As well, not just the District of Columbia.

Dr. FEDER. Yes. And so I will deal with them. I would like to address them all.

Ms. NORTON. OK.

Dr. FEDER. Essentially what we have, when you talk about States with sparse populations, you are generally talking about States with relatively low health care costs. The premiums tend to be lower in those areas, and so I think that that is not a concern that is of particular concern. What I believe you are——

Ms. NORTON. Of course, you're looking now at people, many of whom would be uninsured. When all of these people are in the same pool, can you say that in Montana we're going to continue to have lower health care costs when people are widely disbursed and getting health care to people to whom you've never had an obligation to get health care to now confront you?

Dr. FEDER. Again, let me clarify what we've done in terms of the process in terms of estimating premiums. We have drawn on an extensive body of data with respect to the costs of services for people who are insured, underinsured, and uninsured. And we have taken

into account the costs associated with bringing the uninsured or the underinsured population into the overall system.

And we would be happy to provide you the backup analysis that indicates the care that we have taken in making assessments as to what the cost changes are when we bring the broader population into a system of coverage.

There is evidence that they will—they're already using some care. They are often using it too late and ineffectively. There is evidence that there will be some increased use, as we would expect, and, we would argue, a more appropriate use.

And all of those factors have been taken into account in our estimates of premiums and in our cost estimates for the program. So we feel that we have taken that into account throughout the Nation in a way that gives us confidence about our estimates and our projections.

Ms. NORTON. I'm saying that generally it doesn't much matter what the pool looks like. The fact that people may look very differently from State to State doesn't really matter a lot because you have models that show you——

Dr. FEDER. No.

Ms. NORTON [continuing]. That the premiums will be roughly the same.

Dr. FEDER. No. I didn't mean to imply that. I think you asked several questions, and I was addressing a question about being able to estimate the changes in premiums when a new population is brought. There are different pools in different parts of the country. And one of the reasons that we have a national subsidy pool is to make certain that in no part of the country are employers or employees exposed to unacceptable burdens as a result of those potential variations. That's why we have caps on the obligations for employers, caps on the obligations for employees in order to protect people from variations.

Now, what we do know from the national data is that for the most part, wages and health care costs tend to vary in tandem. And, consequently, for the most part the pool will be distributed similarly around the Nation, but there may be communities—and the District may be one of them—that will be case of the state boundary issue in particular circumstance that creates a larger draw on the pool.

Ms. NORTON. And I would like you to address that.

Dr. FEDER. I think we will need to address that in greater detail for you, but the mechanism is there, essentially. The protections are there for the District, as they are for other communities. That's why we have a national subsidy pool.

Ms. NORTON. And you're satisfied that in large cities around the country, you will be able to match inner cities, where the health care problems are profound, with other pools so that one can get a community rating that will give you reasonably priced premiums?

Dr. FEDER. I think there are concerns where the State boundaries may somewhat truncate the pool, and that is a specific question you're raising. I think that is a matter of concern, although I believe: One, we have the subsidy pool to provide protections; two, we have mechanisms that do not guarantee, but certainly allow, collaboration across State boundaries.

So those are ways in which we have attempted to address this issue, and we are happy to work with you to make further improvements in that regard if you have some proposals in that area. But more broadly——

Ms. NORTON. Risk pools could go across State boundaries?

Dr. FEDER. Alliances could be there. There is a specific provision that allows boundaries across State lines, yes.

Ms. NORTON. With the permission of the other State, I suppose?

Dr. FEDER. Well, that's the issue, I would think. But the other piece that you raised in terms of generally inner cities, that where there——

Ms. NORTON. Because you're quite aware that another State is not going to draw its boundaries so as to let in the pool of some inner city in the adjoining State?

Dr. FEDER. I did not wish to overstate what we—I didn't mean to overstate what the option allows, but it does allow cooperation. And I just wanted to point it out to you.

Ms. NORTON. Does the cooperation mean the alliance would go across State boundaries?

Dr. FEDER. That's right. You would have cooperative alliances in a multi-State area. I think it's important to know we certainly have plans going across State lines. So one of the concerns that a member raised earlier about an individual wanting to use providers across a State boundary and being at the line, those are issues of plan availability. And I see very few problems in that regard. And I think that's somewhat——

Ms. NORTON. So if someone who lives in the District wanted to see a doctor whose office happened to be in Alexandria, the plan is such that you envision that that could be arranged through the alliance?

Dr. FEDER. Well, certainly an individual who chooses an open fee for service plan can go wherever they choose. And that I think is quite——

Ms. NORTON. But beyond that.

Dr. FEDER. Beyond that, essentially, health plans are likely, as they do today in this community, to serve the District and Virginia and Maryland because, essentially, they are serving broad communities in the same health plan.

Ms. NORTON. So if Georgetown University had an HMO and it also had one in Montgomery County, it could continue, even though it is based here in the District, to operate in Montgomery County?

Dr. FEDER. It could operate. I would want to pursue that with you, but essentially a plan can operate in different alliances without any barriers that I see. I think that's certainly possible.

Mr. KING. Madam Chair.

Ms. NORTON. Yes, sir.

Mr. KING. Just as an observation. And I don't mean to oversimplify a very, very complex set of issues, but as you look toward the problem-solving, I think we have a precedent—as you know, Washington is a southern city and, therefore, it doesn't ever snow, but, nevertheless, the surrounding communities have worked out a cooperative arrangement on this. And we have crossed State lines very effectively in both communication and in agreement, so that we can minimize the purchase and use of snow equipment, in part,

by managing our Federal workforce accordingly of designated snow days, Madam Chair.

I would submit that we have been able to cross jurisdictional lines in areas where there was mutual self-interest. I should like to think that we—and I would certainly work with the committee and with you and with any people who were interested—could use the same model to achieve even higher goals.

Ms. NORTON. Let me make myself perfectly clear, Mr. King. There is no mutual self-interest in the rich counties of Maryland and Virginia hooking up with the District of Columbia. There is self-interest for the District of Columbia. And I submit to you that it is hard for me to believe that there are not similar cities across the country.

And this ain't snow. This is health care.

Mr. KING. Well, Madam Chair, I don't——

Ms. NORTON. And when it comes to health care, States and jurisdictions are going to do what insurance companies do. They're going to look for a pool that reduces their costs.

Mr. KING. Or directs resources to a place that provides superb care. And I would use the area I came from, which is Boston. It attracts a universal clientele, whatever the cost is.

Ms. NORTON. They won't mind coming to Georgetown University Hospital. I'm talking about——

Mr. KING. I was thinking: Where is that located, Madam?

Ms. NORTON. Let me be specific. I'm not talking about coming across State lines to the great teaching hospitals located in the District of Columbia or coming to Columbia University Hospital, even though it's in upper Harlem.

What I'm talking about is whether or not it is even realistic to put out here that jurisdictions across State lines would reach to poorer jurisdictions in order to help lower the costs of the poorer jurisdictions.

Mr. KING. But there may be reasons. I would hate to think we would squelch——

Ms. NORTON. Then give me one. I'm looking for one.

Mr. KING. We are working toward that at this time. I would like to see whether that could be——

Ms. NORTON. Well, I would like to hear from you a reason why a richer jurisdiction would do that.

Mr. KING. I don't know, but we might wish to examine it, rather than suggest it won't work in the beginning, Madam Chair.

Ms. NORTON. What I want you to examine because I believe that there is an imperative, a cost imperative, here——

Mr. KING. But I think we both——

Ms. NORTON. What I would like you to examine is what you plan to do if a city, whether or not it is like the District, finds itself isolated with respect to its own pool.

Now, if you're saying that we will subsidize that, then that is an answer. To say that we would hate to think we wouldn't like to do that is not an answer because it is clear that they wouldn't like to do that.

What is not clear is how you make up for that isolation when the jurisdiction you're talking about may be a poor rural area with nothing but poor dirt farmers, maybe in inner cities.

Will these less favored pools, in fact, find places to hook up to? Because if it's based on permission from the richer jurisdiction or State, it's not going to happen, and you and I know it.

Dr. FEDER. Ms. Norton, again I would like to draw some boundaries around the problem. The problem that you raise when State boundaries limit the scope of an alliance, as they do in D.C., that is the problem that I think we've been discussing primarily.

Within States when you talk about rural areas and the boundaries of alliances, let me just clarify for you what it is that we've put into the bill to allow broad—not allow, to require broad pools.

Ms. NORTON. "Require" is the operative word.

Dr. FEDER. That's why I corrected myself.

Alliances, essentially there is a concern about redlining in alliances. And alliances, which would be discrimination based on income, race, health status, whatever the circumstances may be, are explicitly prohibited. Furthermore——

Ms. NORTON. What is explicitly prohibited? I'm sorry.

Dr. FEDER. Defining areas that would be determined to be discriminatory on the basis of income, race, health status——

Ms. NORTON. I'm talking now—I know a State might not do them. I'm talking about when you're brought up against a State line.

Dr. FEDER. Well, that's what I wanted to be clear on because it sounded to me as though your description was broader than that, and I wanted to be very clear that except where an area is limited by State lines, there are very clear prohibitions on discrimination in the structure of those alliances and very clear requirements that metropolitan areas, full metropolitan areas, not be divided.

Ms. NORTON. I suppose all I want to suggest is that you take a look. There are probably a very few jurisdictions like this, but they are the ones that could spoil the brew. Take a look at jurisdictions that are brought up against State lines or like the District of Columbia, and that would be an anomaly and a unique situation——

Dr. FEDER. Right.

Ms. NORTON [continuing]. Or, in fact, simply isolated from any pool, and suggest what you think should be done with jurisdictions like that.

Could I just ask you right here while I have you: Will you look at the District of Columbia, in particular, and suggest to this committee, the District of Columbia having the largest number of Federal employees per capita of any state except the State of California—would you suggest to this committee how you propose to handle the unique situation of the District of Columbia? And when can I get that information from you?

Dr. FEDER. I will follow up, and I will follow up as quickly as possible. I would also want to reiterate, as you indicated in responding to me, that, essentially, with respect to the guaranteed protections for employers and employees in the District in terms of the discounts, that we believe we have dealt in a considerable respect with any problems that might arise, but I would be glad to pursue it further and will do that.

Ms. NORTON. Thank you, Dr. Feder.

I am pleased to turn the chair back over to its rightful owner. [Laughter.]

Mr. CLAY [presiding]. Thank you, Congresswoman.

Mr. McCloskey.

Mr. MCCLOSKEY. Thank you very much, Mr. Chairman.

I might say to my good friend Mr. King, given some recent developments, the informal meeting we were going to have after this meeting, Jim, is more important than ever. I know the Chairman also would appreciate it.

Jim, you've worked tremendously well. I think we're very hopeful for my legislation regarding temporary employees. I think part of the dialog has been that temporary employees ultimately, even beyond my legislation, would be massively benefited once the national health plan becomes operative.

Specifically, assuming this passes next year, what happens to temporary employees in the Federal service?

Mr. KING. As you know, once the national health care program, the Health Security Act, went in, it doesn't distinguish between permanent and temporary in its coverage provisions. So the temporary employees will be covered by their regional alliance with an employer contribution.

Mr. MCCLOSKEY. That's ultimately come post-1998 and beyond, as you see it right now?

Mr. KING. Right.

Mr. MCCLOSKEY. Assuming my legislation goes through this term, you would assume——

Mr. KING. We're going to work with the committee as a separate issue to make that available to them.

Mr. MCCLOSKEY. In the meantime.

Mr. KING. We would act as soon as possible and within what the committee recommends to get them on so it's available to them. But, as you know, there's still that cost factor, and we understand that being somewhat of a bother for your lower income folks.

Mr. MCCLOSKEY. I'm sorry, Jim. It might be my hearing. I'm kind of missing some of your——

Mr. KING. I'm sorry. My apologies. What we're concerned about is: first, we'll make insurance available under the law immediately to the temporaries as that law comes forward. We have the ability to put the folks right on. This would phase them right on over so that they're covered at the State level.

And they would be the exception, I believe, on transition. They would go sooner, rather than later, as it were, into the health care, to the national program.

Mr. MCCLOSKEY. OK. Changing to the broader issue as to Federal employees and assessing coverage for Federal employees, I think your statement alludes to the fact that assuming Federal employees spin off into I guess regional alliances, they would have—I guess one selling point would be they would have the national security; is that not right, as far as catastrophic preexisting conditions and you didn't mention it, but community-based pricing, rather than—in some ways I guess community-based pricing would almost be automatic as far as the theory and practice; right?

Mr. KING. They're looking at virtually the same plans they've been looking at all of these years. It's just a question of where the payment would originate from. And it would come at the State

level under whatever arrangement is made—the bureaucracy or the management device to pay it.

It moves away from us at OPM to another location.

Mr. MCCLOSKEY. I understand.

Mr. KING. But the programs they would be looking at are virtually the same programs that they are looking at, at present—they'll be looking at the same programs. And, as you know, those programs are mix and match.

I mean, they have good things, very good things, in certain plans, a little less in others. And what everyone does is look and see what's best for them or their family, I guess I should say.

Mr. MCCLOSKEY. Yes. I don't know that I would raise it as dramatically as the Chairman has, but I suppose part of his thinking is that, well, equality is one thing, but Federal employees will have this opportunity to be so benefited by going off into the regional alliances come 1998.

Obviously, as it stands now, the cutoff line if companies want to stay in their own corporate alliance is 5,000 employees. I think there are going to be some problems with that at some point: arbitrary cutoff dates and so forth or cutoff amounts in the private sector.

But what happens under the health plan as far as people in the corporate alliances, in regards to standards they have to make for catastrophic national, total family security, or preexisting conditions? In essence, will they be also mandated into coverage that they don't provide now?

Mr. MCCLOSKEY. Dr. Feder.

Dr. FEDER. "Yes" is the short answer. Essentially, we are providing all Americans with guarantees of security. Whether they be in corporate alliances or regional alliances, essentially they have the guaranteed package. They have a choice of plans. They have quality programs in their plans. They have the same array of protections.

Mr. MCCLOSKEY. OK. Well, we're about a year away now. And, obviously, it's going to take a lot of work and many hearings. So I appreciate your help today.

Thank you, Mr. Chairman.

Mr. CLAY. Mrs. Morella.

Mrs. MORELLA. Thank you, Mr. Chairman.

I have a statement I would just like to ask permission to have included in the record.

[The prepared statement of Hon. Constance A. Morella follows:]

PREPARED STATEMENT OF HON. CONSTANCE A. MORELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Thank you, Mr. Chairman. I have always thought that adequate health care and affordable health insurance are among the most essential needs of our country.

Though Federal employees and retirees have been covered under the Federal Employee Health Benefit Program (FEHBP) for over thirty years, this program has not always been thought of in a favorable light. I remember that during the 100th Congress, we were wrestling with double digit premium increases. In fact, in the preface of our own committee's Report on the Federal Employees Health Benefits Program, the Chairman wrote, "The program continues to suffer from the same inflationary pressures that are affecting health care costs nationwide. Moreover, the program's structural problems exacerbate these inflationary pressures as well as create additional, unnecessary costs for enrollees. Premium costs continue to grow at a pace twice the rate of inflation and more than twice the rate of Federal workers' annual

pay raises—while enrollees face possible benefit reductions." Several studies have been conducted regarding FEHBP: in 1981, the Mercer study; the 1987 study by Towers, Perrin, Forster and Crosby; in 1988, the Congressional Research Service study; the 1992 GAO Report; and the most recent 1992 study by our Committee consultants, Messrs. Creedon, Allison, Mellman, and Sherman.

The reason I'm relating this, Mr. Chairman, is simply to emphasize that as good as FEHBP is, there are still problems. First, the "rest of the universe" should not think that federal employees and retirees have health insurance which is superior to theirs—something they are trying to save for themselves. Simply, FEHBP is a familiar program which the federal sector understands.

The President's plan is very ambitious. I cannot believe, though I would like to, that a perfect plan will emerge as soon as the ink dries on the signature of the Public Law. FEHBP has been in existence for thirty years and there is still room for improvement.

I think that the concept of the Health Security Act is easier for the federal sector to grasp than the rest of the public. The states will be in the position of the Office of Personnel Management—making the decisions and negotiating contracts. However, Mr. Chairman, I would like to commend you for contacting the President and Mrs. Clinton and getting a commitment from them that the FEHBP will not be included in the health care package until January 1998, when all the states have the alliances in place. I would like to suggest that a small amendment be made to the commitment: FEHBP should not be transferred into the national health care reform package until January 1998 or until all the states have their alliances in place, whichever is later. This is simply so that all participants in the FEHBP have uniform coverage.

Members of the Federal Government Service Task Force wrote to the President on October 22 explaining that FEHBP participants of a fee-for-service plan currently have 100 percent coverage for hospitalization; any diminution of this benefit would be a significant reduction in benefits for enrollees in this category. We also expressed our concern about the OPM Medigap plan. It is our hope that the proposed OPM administered Medigap plan should provide the same level of coverage that Medicare enrollees now receive. Indeed, some interested parties have asked me, if the new plan is as good or better than the current FEHBP, why should we have supplemental plans to enjoy the same level of coverage?

Mr. Chairman, I have reviewed the testimony of the Director of the Office of Personnel Management and find that it is rather sketchy. I appreciate that the witness is probably using this flexibility to have more time to answer questions. I hope that at some point they will explain how the Health Security Act will cover Americans who are traveling abroad, living abroad, working abroad, or representing our country abroad. I realize that the Act is not crafted to cover foreign nationals in our country, but how do we cover our nationals in other countries—what reciprocity will there be? I know that many of our federal employees—not just State Department or Foreign Service officers—serve abroad: Peace Corps, Department of Agriculture, Department of Labor, etc. I want to be assured that they will be fully covered to the same extent as every American national.

Mr. Chairman, I appreciate the fact that, under a national health plan, employees can move from job to job without being chained to their health benefits—somewhat analogous to permitting FERS covered employees to have the option of moving from federal to private sector jobs without losing retirement benefits. The flexibility will, I am sure, be a morale booster in most cases.

I will have additional questions for the witnesses and I appreciate your giving me this time, Mr. Chairman, to make a few comments.

Mrs. MORELLA. Just a few random questions, if I might pose them. Incidentally, I'm going to have open season on the Federal Employees Health Benefit Plan.

I want you to know a lot of people have called the office with great anxiety about what is actually going to happen with the reformed health plan. I have other people who are contacting us to find out more about the health care who are not Federal employees or retirees. So I just want you to know that everybody is very anxious—anticipatory.

I just have a few questions that you may not have answered. First of all is a statement. The FEHBP has been in existence for

30 years. We think it's a pretty good plan, but it still needs some improvement.

That being said, it is going to be rather miraculous to come up with a reformed plan that is not going to need some enormous improvement that is going to be the reform, just as a kind of preface to what you're going to be undertaking.

I also want to thank the chairman for the letter that he wrote to President and Mrs. Clinton asking that we don't have the FEHBP become part of the other alliance until January 1998.

I might suggest, too, that we might add a proviso to that which would say that FEHBP shouldn't be transferred into the national health care reform package until January 1998 or until all of the States have their alliances in place. Just in the event they're not already—at least we have that proviso; right?

Dr. FEDER. And they are supposed to all be there prior to coming in on that date.

Mrs. MORELLA. But we just become very—well, I was going to say skeptical. I don't quite mean skeptical. We just want to make sure that——

Mr. CLAY. Will the gentlelady yield?

Mrs. MORELLA. Yes, indeed.

Mr. CLAY. I assume that you're presuming also that the health alliances will come up to where the standards are for FEHBP at this point. You're not anticipating Federal employees losing any benefits or paying any more for those benefits.

Mrs. MORELLA. Of course not, Mr. Chairman. I certainly don't assume that. As a matter of fact, I was going to ask——

Mr. CLAY. As a matter of fact, you ought to ask her if that's feasible. [Laughter.]

Mrs. MORELLA. Then, indeed, I shall. Maybe that should be part of the reservation or the conditions under which the new system takes effect.

But speaking of that, what about the supplemental plans? Can you comment on how that would go into effect, the need for——

Dr. FEDER. Actually, I think that I will defer to Mr. King in a comment, but let me just comment because we've talked a lot about supplementation and I think that it's important to have some perspective here.

As we indicated earlier, the benefits that the President's plan is proposing are quite comprehensive and differ, I would say, only at the margin from current Federal employee benefits.

So that as we talk about an issue of possible supplementation, I don't want to exaggerate the differences. The benefits in the President's package are better with respect to preventive services and catastrophic protection as well as—I mean, they are very similar in providing the full array of benefits and choices.

The dental health benefits for adults and mental health benefits are not fully phased in until 2001. So for a period, there are some differences from some plans in the Federal employees program.

And then in the high cost-sharing plan, which is not the only option that an individual has, there is a 20-percent hospital co-pay, as opposed to a $250 deductible, on hospitalization. Again, that 20 percent is cap because there's that out-of-pocket protection at

$1,500 for an individual. And if an individual beneficiary chooses a low cost-sharing plan, then this differential doesn't exist.

So the differences really are quite modest, and that's what I wanted to emphasize before talking about the approach to supplementation.

Mrs. MORELLA. In many instances, though, with many of the Federal plans, there is just no need for any co-pay. I mean, the hospitalization is 100 percent paid for?

Dr. FEDER. No. In network, essentially, that may be true. And that is the same approach that the President's plan takes.

Mr. KING. At least it's my hope because, as I mentioned, I was looking for the Government to be competitive in offering whatever benefits they offer, co-pay or anything else. If it's being offered in the marketplace, it should be offered at the Federal level. And if it's at the margin, it should be offered as a model employer.

But that's what we're seeing for the most part. There are some gaps, as you know, especially among our older retirees, and we're hoping that those will be filled in through this process. So there are some out there, as you're sensitive to and aware of, and we would like to fill that in.

What we would also like to do at this time is standardize in a broader context—as we've talked about in other hearings—all of the benefits, especially for the retirees, so that there isn't a question mark as to what lies in the future.

Mrs. MORELLA. You know, we are in our open season period—and I'm holding health forums next week on Monday. We got a notice that there was a chance the White House could send somebody. And I have availed myself of that invitation in the hopes that an expert could be there at the end of my program to respond to some of those concerns.

Mr. KING. I think I could identify a person who could find us an expert, and she's on my left.

Dr. FEDER. We would be happy to proceed with that.

Mrs. MORELLA. I'm also curious, if I just might, Mr. Chairman: What do you do about civil servants who are serving overseas? I don't know whether you addressed that before or not.

Mr. KING. Our plan now covers everyone if you're employed in a permanent position and if you're an American citizen. And it would continue to function. That would function abroad and also if you came back here on leave. We're working that into the entire plan.

Mrs. MORELLA. What about the temporary employees? What about part-time employees?

Mr. KING. Temporary employees would have the benefit—we're hoping, with Mr. McCloskey's leadership—we'll make a health care component available to them, the same thing as part-time, but with full payment by the individual.

When this program goes through, with the Federal Government being an employer, both part-timers and temps would go on over into their State program or regional program and be covered and get an employer contribution. So there would be a definite benefit to temporaries.

Mrs. MORELLA. I'm sure that I will have some other questions at another point, but thank you very much.

Thank you, Mr. Chairman.

Mr. CLAY. Thank you.

Mr. Bishop.

When she was talking about supplementals, this bill authorizes but does not require OPM to offer supplemental benefits to Federal employees and future retirees. Why does the administration, then, refuse to make a no-take-away guarantee to its workers and future retirees?

Dr. FEDER. The perspective has been essentially that the Federal Government ought to be an employer that is competitive with what is generally available in the marketplace and retains that option to view the supplement, as Mr. King indicated, to develop those policies as appropriate, as the marketplace is changing. That's the perspective behind the policy.

Mr. CLAY. That's why you're treating current employees differently than the new ones and——

Dr. FEDER. Well, I think the issue is it seems that, as Ms. Morella indicated, there is anxiety and, I would also hope, a lot of hopefulness as far as reform is concerned.

And it has been our view that it is very important that retirees understand that their benefits are affected, that changes in the system will be made whole, that there are specific mechanisms to achieve that objective. And so we have made a specific commitment in that regard.

Mr. CLAY. With regard to those changes, you estimated between 1995 and 2000 your plan will save $13.2 billion. Does that estimate assume that OPM would not be required to offer supplemental benefits to employees and new retirees?

Mr. KING. I would think that the door's not closed on anything, Mr. Chairman. Again, we would like to remain competitive with what's going on out there in America, in the competitive world and, again, not playing behind, that we can provide a leadership role on certain issues that should be addressed, actions that should be done.

So as a personnelist, rather than a budget person, I am going to always speak to those issues that enhance the employees' benefits and wages and working conditions, whenever humanly possible, and then have the costs chase tnat.

Mr. CLAY. I don't know whether you can do it now, but can you provide us for the record where you're going to save the $13.2 billion?

Mr. KING. We have numbers, and we can get that for the record, Mr. Chairman.

Mr. CLAY. Thank you.

Ms. Morella, any more questions?

Mrs. MORELLA. No, I think not at this point.

Mr. CLAY. Mr. McCloskey? Mr. Bishop?

We certainly want to thank you for your testimony. That concludes the hearing for today.

Mr. KING. Thank you, Mr. Chairman.

Mr. CLAY. Thank you.

Mr. KING. And, again, thank you for your leadership.

[Whereupon, at 2:57 p.m., the committee was adjourned.]

HEARING TO CONSIDER VIEWS OF EMPLOYEE ORGANIZATIONS ON THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL, HEALTH SECURITY ACT OF 1993

THURSDAY, NOVEMBER 18, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, DC.

The committee met, pursuant to call, at 10:05 a.m., in room 311, Cannon House Office Building, Hon. William Clay (chairman of the committee) presiding.

Members present: Representatives Clay, McCloskey, Ackerman, Sawyer, Collins, Byrne, Bishop, Morella, and Petri.

Mr. CLAY. The full committee will come to order.

This morning the committee continues its consideration of the President's proposal to reform the Nation's health care system.

As a part of the Clinton plan, the President will propose that the Federal Employees Health Benefits Program be abolished and that Federal employees and retirees be enrolled in State regional health alliances.

As I have said on several occasions, the committee has very grave concerns about abolishing a generally well-run program that serves 9 million people and has been an important employee benefit for over 30 years.

Further, the committee should not abolish the program unless it is sure that it is in the best interests of Federal employees and retirees.

Consequently, the committee is interested in the views of Federal employee and retiree organizations on this proposal and on the effects they believe the proposal will have on their members and their members' health benefits. The committee must know what effect the administration's proposal will have on the health benefits and out-of-pocket costs of FEHBP enrollees. Will Federal employees pay more or less, is the $64,000 question.

I for one cannot support a change in Federal employee health benefits that would leave Federal employees and retirees worse off. But let me add that I would be very ambivalent about a change that left Federal employees no worse off either. If the Clinton plan is to be enacted, our goal should be to ensure that Federal employees and retirees are better off than they are now.

The President believes that under his plan, every American, including Federal employees, would be better off; and, in the end, the committee might agree with him. I hope he is right. But for now,

the committee must examine all of the evidence and weigh whether the President's proposal is the right thing to do.

I look forward to this morning's testimony. I am going to have to leave for a few minutes, and Mr. McCloskey is going to Chair the hearing. We are in the unfortunate position in the State of Missouri where we don't have a Democratic Senator. Therefore, it becomes the responsibility and, indeed, a hard task for members of the House of Representatives to recommend Federal appointees to the President. And this morning I have the honor of going before the Senate to introduce my selection for United States Federal judge. So I will be gone for a few minutes, and Congressman McCloskey will chair.

Thank you.

[The prepared statements of Hon. William L. Clay and Hon. Eleanor Holmes Norton follow:]

PREPARED STATEMENT OF HON. WILLIAM L. CLAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

This morning, the committee continues its consideration of the President's proposal to reform the Nation's health care system.

As a part of the Clinton plan the President will propose that the Federal Employees Health Benefits Program [FEHBP] be abolished and that Federal employees and retirees be enrolled in the State regional health alliances.

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Consequently, the committee is interested in the views of Federal employee and retiree organizations on this proposal and on the effects they believe the proposal will have on their members and their members' health benefits. The committee must know what effect the administration's proposal will have on the health benefits and out-of-pocket costs of FEHBP enrollees. "Will Federal employees pay more for less" is the $64,000 question. I, for one, could not support a change in Federal employee health benefits that would leave Federal employees and retirees "worse off."

But let me add that I would be very ambivalent about a change that left Federal employees "no worse off" either. If the Clinton plan is to be enacted, our goal should be to ensure that Federal employees and retirees are better off than they are now. The President believes that under his plan every American, including Federal employees, would be better off, and in the end, the committee might agree with him. I hope he is right. But for now, the committee must examine all the evidence and weigh whether the President's proposal is the right thing to do.

I look forward to this morning's testimony.

PREPARED STATEMENT OF HON. ELEANOR HOLMES NORTON, A REPRESENTATIVE IN CONGRESS FROM THE DISTRICT OF COLUMBIA

Throughout this Committee's examination of the Administration's health care reform plan, one of our greatest concerns must be the level of health benefits employees receive. These benefits are a part of an employee's earned wages. If health care benefits are no longer available at a comparable cost, the functional equivalent of a wage cut occurs. On the basis of the Office of Personnel Management's (OPM) testimony at our hearing last week, I am not convinced that Federal employees would have an employer willing to pay its fair share for employee health care.

The Administration's plan offers fewer benefits than are currently available through the Federal Employees Health Benefits Program (FEHBP). The Administration's plan, for example, limits hospitalization coverage in fee-for-service plans to 80 percent when, under the current FEHBP, 100 percent of this cost is typically covered. In addition, under FEHBP, Federal employees can receive dental coverage, but the Administration's plan does not provide complete dental coverage until the year 2001—four years after the proposed dissolution of FEHBP.

These "gaps" between what Federal employees can receive now under FEHBP and what the Administration's plan provides can be filled by supplemental benefit plans. OPM has said it will offer supplemental plans to current retirees, but only may offer them to future retirees and active employees. We have not yet learned the scope of the supplemental package OPM is prepared to offer, or what share of premiums the employer and employee will pay. Surely it is fair to expect that OPM will guarantee supplemental benefits that will ensure that Federal employees are made whole and do not have their wage-benefit package precipitously cut.

Federal employees have emphatically indicated that they value their health care benefits above all others. This year, Federal employees have been asked to make enormous sacrifices to enable the Administration to achieve its deficit reduction goals. Surely there must be limits on what a single group of American workers should be asked to sacrifice.

I welcome today's witnesses and look forward to hearing your testimony.

Mr. McCLOSKEY [Presiding]. Thank you very much, Mr. Chairman. It is great to back up a man of such power.

Is Mr. Hoyer or Mr. Moran here?

Let's proceed, then, with our first panel. As I recall, one of them was Mr. Sturdivant; of course, I'm looking forward to his excellent testimony. Also, Robert Tobias, national president of the National Treasury Employees Union, Charles W. Carter, president, National Association of Retired Federal Employees, and Mr. Gene Voegtlin, representative for the Federal Managers Association.

I have just been told that Mr. Tobias should be here shortly.

Gentlemen, welcome. I appreciate you being here to testify on this very important subject on this post-NAFTA day. We are going to have a very successful year next year working on health care, John, and this helps lay the base.

Why don't you give us your statement, and your formal statement will be accepted for the record.

And I recognize the gentlelady from Maryland.

Mrs. MORELLA. Thank you, Mr. Chairman.

I just wanted to say now that we are after NAFTA, we will start looking at what is critically important. I wanted to share that I did have two hearings for the open season for the Federal Employee Health Benefit Plan, and at one of them, the administration sent a representative at the end of the meeting to respond to any questions that they may have. He later said he faced "a tough crowd."

And so I just want to reiterate, Mr. Chairman, that the Federal retirees like the FEHBP; they didn't mince any words in expressing their sentiments at those meetings. They expressed that Federal retirees are committed to including long-term care, universal coverage, affordability, accessible quality benefits, cost containment, and portability.

They said that any proposal which allows major corporations to continue their own alliances must allow FEHBP to continue and, furthermore, the care and coverage currently available in FEHBP must be maintained. So you are nodding affirmatively, which must mean that we are all hearing the same kind of thing.

So I particularly look forward to hearing from our witnesses.

Thank you, Mr. Chairman.

Mr. McCLOSKEY. Thank you, Mrs. Morella.

Mr. Sawyer, do you have a statement?

Mr. SAWYER. Mr. Chairman, I will forego an opening statement.

Mr. McCLOSKEY. Ms. Byrne, would you like to make a statement?

Ms. BYRNE. I have a statement that I will put into the record, Mr. Chairman. But I associate myself with the comments of the gentlewoman from Maryland.

Mr. MCCLOSKEY. The statement is accepted for the record.

[The prepared statement of Hon. Leslie L. Byrne follows:]

PREPARED STATEMENT OF HON. LESLIE L. BYRNE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

I would like to take this opportunity to commend you for your leadership of this Committee as we begin to discuss health care reform, and I also want to thank the witnesses for taking time out of their very busy schedules to testify before us today.

With over 70 health care reform plans before Congress, we will need to examine every option carefully, and I am sure that this hearing will shed some light on which option is the fairest and most equitable way to go for the federal work force.

I would also like to commend the Clinton administration for taking a major step towards comprehensive reform by placing this issue on the front burner. I think we all agree that we would not be having this discussion today if it wasn't for their dedication and hard work.

The president's plan has succeeded in changing many of the parameters of the debate. No longer is the idea of universal coverage considered to be an unworkable fantasy, and preventative care is now being viewed by all sides as a necessary ingredient of reform.

However, the president's plan still leaves some questions unanswered, and the question at the top of my list is: if we are trying to set up a system that offers a choice of plans, keeps costs down and provides quality health care to its subscribers, why should we eliminate a program that already does those things?

At last week's hearing, representatives from the administration testified that they are not, in fact, eliminating the Federal Employees Health Benefits Program and putting federal workers in with the rest of the country, but are actually making a bigger FEHBP and putting everyone in the country into it.

I admire their optimism, but the fact remains that the FEHBP is the only federal health program that would be completely dismantled under this plan, and federal civilian workers would become the only group of employees over 5000 who do not have the option of creating an independent corporate alliance.

I am confident that everyone in this room today is committed to working with the president and the entire Congress to fashion a health care reform plan which will expand access, lower costs and maintain quality. But I think we need to make sure that federal employees are not taken for granted.

Once again, I thank the Chairman for his diligent work on behalf of federal employees, and I look forward to an informative hearing.

Mr. MCCLOSKEY. I do notice that Mr. Hoyer is here. And in your mild tardiness, I brought this distinguished panel on.

Would you have 15 minutes or so? Or would you prefer to come up and give your statement and proceed from there? You do have legislative eminence. I think the panel has decided for you, Steny. I think that is understandable.

I would note that it is a very brief statement, and I don't know what questions are going to be asked. So Congressman Hoyer, welcome. Your statement is accepted for the record.

I guess you were going to be joined by Mr. Moran, but, obviously, he is not here yet.

STATEMENT OF HON. STENY H. HOYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. HOYER. I apologize for being late.

Mr. Chairman, as you know, there are a lot of things going on, and we just got through the whip meeting and some other issues of concern, like the reconciliation or rescission package that we are going to be talking about.

Mr. Chairman and members of the committee, I want to thank you for this opportunity to appear. I saw Chairman Clay on the way down, and he wished me well.

The President and Mrs. Clinton are to be applauded for engaging the Nation in the long overdue debate on the state of the Nation's health care system.

I, like you, Mr. Chairman, believe that successful passage of this legislation is a must. In your statement of November 9—and I believe this refers to Chairman Clay's statement—as you presided over this committee's first hearing on this issue, the Chairman indicated that he had, and I quote, "grave concerns with the President's proposal to enroll Federal employees and retirees in 1998 in the State regional health alliances and to abolish the Federal Employee Health Benefit Program." I agree that we must work together to address the concerns of our Federal employees.

I realize the committee is in the process of developing a comprehensive picture of the administration's proposal. There are, however, several issues that my constituents and all of your constituents have identified as concerns.

Recently, at a town meeting devoted to the Clinton health care proposal, Federal employee participants expressed grave concerns about the news reports regarding the proposed levels of coverage and possible premium increases facing Federal employee if the health care proposal were enacted today.

Approximately 65 percent of the 9 million Federal workers, retirees, dependents, and survivors who are enrolled in the FEHBP are participating in a fee-for-service plan. These enrollees have 100 percent coverage for the cost of inpatient hospitalization.

The administration's health care proposal, as you know, requires a 20-percent coinsurance payment for inpatient hospitalization, representing a significant reduction in benefits for current FEHBP enrollees with fee-for-service plan.

This reduction would represent a significant inequity and must be addressed, as this committee is doing. The Office of Personnel Management Director James King's testimony before this committee on November 9 further raised my concerns about the future of health benefits for Federal employees.

Director King indicated that all Medicare eligible retirees in the FEHBP at the time of enactment of national health care legislation will be protected against both premium increases and benefit cuts.

Director King continued that this will be accomplished by having the OPM provide a supplemental policy that will make up for any differences. The guarantee of this protection, however, is not offered to current Federal employees or future Federal retirees, as I understand it.

Director King stated that, and I quote, "the act would further permit OPM to offer one or more supplemental health plans to current employees and future retirees, with or without Medicare availability on the same basis," close quote.

My concern is that this language indicates a possible signal that our current benefit levels will not remain the same after Federal employees enter their perspective regional alliances, and that the employer is not under any obligation to maintain the current level of benefits.

We should be extremely cautious to avoid a two-tiered system with a different benefit level for future retirees, the concern we had, as you know, in the FERS, CSRC problem.

Representative Gary Ackerman alerted the committee to statements made by the Department of Treasury Secretary Lloyd Bentsen.

Secretary Bentsen indicated that private sector employers who save money by paying lower premiums will be able to share those savings with their employees in the form of higher salaries. The employees will, of course, benefit but so will the Federal Government in the form of higher tax revenues.

OPM has indicated that the administration will realize a savings, of $13 billion from fiscal year 1995 to 2000, of the money spent from Federal employee health—for Federal employee health care. However, before these funds are removed from the Federal employee compensation package, I hope this committee will take a careful look at any proposal to reduce benefits such that Federal workers can be assured that they are not, once again, lone victims in our battle to reduce the deficit.

Mr. McCloskey, members of the committee, I want to again congratulate you and the Chairman for having these hearings.

I know because I see the array of members on this committee who are all experts as it relates to Federal employee pay and benefits and are all deeply committed on both sides of the aisle to maintaining the pay and benefits of Federal employees, not only for the benefit of those employees, but for the benefit of the Nation so that we can recruit and retain the best possible people as we face some of the most difficult challenges that our country has faced, and some of the most significant transitions that our country will experience.

I thank you, again, Mr. Chairman. And I want to thank my distinguished friends from the public employee community, both active and retirees, for yielding this time.

I have another meeting at 10:30, so I appreciate that consideration.

Mr. McCloskey. Well, thank you, Mr. Chairman, for an excellent and forthright statement. We appreciate your leadership and your expertise also.

[The prepared statement of Hon. Steny H. Hoyer follows:]

Prepared Statement of Hon. Steny H. Hoyer, a Representative in Congress From the State of Maryland

Mr. Chairman and Members of the Committee, thank you for the opportunity to present my views and the concerns of my constituents in Maryland's 5th Congressional District.

The President and Mrs. Clinton are to be applauded for engaging the nation in the long over-due debate on the state of the nation's health care system. I, like you Mr. Chairman, believe that successful passage of this legislation is a must for our nation.

Mr. Chairman, in your statement of November 9, as you presided over this Committee's first hearing on this issue, you indicated that you "have grave concerns with the President's proposal to enroll Federal employees and retirees, in 1998, in the State Regional Health Alliance and to abolish the Federal Employees Health Benefits Program (FEHBP)." I agree that we must work together to address the concerns of Federal employees.

I realize the Committee is in the process of developing a comprehensive picture of the Administration's proposal. There are, however, several issues that my constituents have identified as concerns that I would like to share with you today.

Recently, at a Town Meeting devoted to the Clinton health care proposal, Federal employee participants expressed concerns about news reports regarding the proposed levels of coverage and possible premium increases facing Federal employees if the health care proposal were enacted today.

Approximately 65 percent of the 9 million Federal workers, retirees, dependents, and survivors who are enrolled in the FEHBP are participating in a fee-for-service plan. These enrollees have 100 percent coverage for the cost of inpatient hospitalization. The Administration's health care proposal requires a 20 percent coinsurance payment for inpatient hospitalization representing a significant reduction in benefits for current FEHBP enrollees with fee-for-service plans. This reduction would represent a significant inequity and must be addressed.

The Office of Personnel Management (OPM) Director James King's testimony before this Committee on November 9, further raised my concerns about the future of health benefits for Federal employees. Director King indicated that all medicare eligible retirees in the FEHBP, at the time of enactment of national health care legislation, will be protected against both premium increases and benefit cuts. Director King continued that this will be accomplished by having the OPM provide a supplemental policy that will make up for any differences.

The guarantee of this protection, however, is not offered to current Federal employees or future Federal retirees. Director King stated that "the act would further permit OPM to offer one or more supplemental health plans to current employees and future retirees (with or without medicare availability) on the same basis." My concern, is that this language indicates a possible signal that current benefit levels will not remain the same after Federal employees enter their prospective Regional Alliances and that the employer is not under any obligation to maintain the current level of benefits.

We should be extremely cautious to avoid a two-tiered system with a different benefit level for future Federal retirees.

Representative Gary Ackerman (D–NY) alerted the Committee to statements made by the Department of Treasury Secretary Lloyd Bentsen. Secretary Bentsen indicated that private sector employers who save money by paying lower premiums will be able to share those savings with their employees in the form of higher salaries. The employees will of course benefit, but so will the Federal government in the form of higher tax revenues. OPM has indicated that the Administration will realize a savings, of 13 billion dollars from FY 1995–2000, of the moneys spent from Federal employee health care. However, before these funds are removed from the Federal employee compensation package, I hope this Committee will take a careful look at any proposals to reduce benefits such that Federal workers can be assured that they are not once again lone victims in our battle to reduce the deficit.

I commend you for this hearing and I look forward to working with you.

Thank you.

Mr. MCCLOSKEY. I note that we have been joined by Chairperson Collins.

Barbara, would you have a statement?

Miss COLLINS. Mr. Chairman, I would like to ask unanimous consent to enter my statement for the record.

Mr. MCCLOSKEY. OK.

Miss COLLINS. Thank you.

Mr. MCCLOSKEY. Without objection.

[The prepared statement of Hon. Barbara-Rose Collins follows:]

PREPARED STATEMENT OF HON. BARBARA-ROSE COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I am very pleased to join you and the other distinguished members of the Post Office and Civil Service Committee in discussing this very important matter of health care.

I would like also to take this opportunity to thank our panel of witnesses for taking the time to share with us their views on the administration's health care plan.

I am particularly concerned about how the President's plan will affect Federal and Postal employees. If the Federal Employees Health Benefits Program [FEHBP] is abolished, how will the benefits and cost differences affect the average Federal

worker? Will the proposed benefits be as good as their current benefits and the costs comparable?

Clearly, there is room for improvement in the current health benefits provided to Federal employees, but the President's plan should not leave them worse off.

We must look, with a critical eye, to ensure that Federal employees do not pay more than they currently do and that their benefits do not decrease.

We need to know exactly what benefits will be offered and at what costs. If there is a decrease in benefits, what will be eliminated? If there is an increase in costs, how much will it be?

We must require that the administration give us accurate and definite answers. Simply stating that Federal workers will be "no worse off" is unsatisfactory.

The absence of universal health care coverage for Americans is an embarrassing scar on our national reputation and a hole through which too many Americans fall.

The lack of universal coverage particularly hurts African-Americans:

22 percent of African-Americans are uninsured.

African-Americans live five to seven years fewer than white Americans.

Heart Disease is twice as common among African-Americans.

We must make sure that whatever plan we adopt provides universal health care at a cost that all Americans can afford.

Mr. MCCLOSKEY. Mr. Sawyer.

Mr. SAWYER. Thank you, Mr. Chairman.

I really don't have questions for you, Steny, but I would just like to associate myself with your comments and observations. The strength of the Federal work force and the capacity to treat them with the same range of flexibility that private sector employers are able to treat their valued employees is important to being able to maintain the quality of governance in this country that all too often we take for granted but really is the product of enormous ongoing effort.

Thank you for your comments this morning.

Mr. HOYER. Thank you.

Mr. MCCLOSKEY. Mrs. Morella.

Mrs. MORELLA. I just wanted to welcome and thank my colleague from the Maryland delegation. We work very well together, especially on Federal employee issues.

Steny, thank you for the leadership that you have shown on this regard. It is good to have you on Appropriations.

Mr. HOYER. Thank you. It is good to be there, most of the time. If you very kind and conscientious people on the authorizing committees will allow us to continue to operate, we would be very happy.

Mr. MCCLOSKEY. Ms. Byrne.

Mrs. BYRNE. I have no questions.

Mr. MCCLOSKEY. Steny, thank you very much. Really great to see you today.

Mr. HOYER. Thank you very much, Mr. Chairman.

Thank you.

Mr. MCCLOSKEY. We have now been joined also by Mr. Tobias. So I welcome you.

And as I was saying to the panel earlier, welcome again. Your statements are accepted for the record.

And, John, why don't you give us your observations.

STATEMENTS OF JOHN STURDIVANT, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ROBERT TOBIAS, NATIONAL PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION; CHARLES W. CARTER, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES; AND GENE VOEGTLIN, LEGISLATIVE REPRESENTATIVE, FEDERAL MANAGERS ASSOCIATION

Mr. STURDIVANT. Thank you, Mr. Chairman.

First, let me thank the members of the committee for your diligence and your steadfastness in support of the pay and the benefits and the working conditions of Federal workers. I want to thank you on both sides of the aisle for the work that you have done on behalf of our members.

Of course, it is always good to see Ms. Byrne who represents the 11th Congressional District of Virginia in which I live, and who has made history in Virginia. And I helped. And hopefully with your support for Hatch Act reform, we will be able to do something next year about that, too.

Mr. Chairman, members of the committee, on behalf of the 700,000 Federal and District of Columbia employees that our union represents, the AFGE, I thank you for the opportunity to testify today.

AFGE has been active for many decades in an effort to reform our Nation's health care system, and it is, therefore, a pleasure to come before you today to engage in a discussion in how to improve an already excellent blueprint for guaranteeing every American high-quality and affordable health insurance.

AFGE has been highly critical of the Federal Employees Health Benefits Program, despite the fact that the approach to providing access embodied in President Clinton's plan appears to be modeled loosely on the FEHB, we believe that it is structurally superior to FEHB in many ways.

In particular, it avoids risk segmentation by specifying a minimum standard benefit package. It avoids cost shifting by providing universal coverage. And, perhaps most important, it provides genuine cost containment through global budgeting and coordinated allocation of health care technology.

The most critical failing of FEHB from the perspective of employees has been inadequate employer financing. In 1989 the Congressional Research Service conducted a comprehensive analysis of FEHB and found, on the average, the Federal Government paid about $1,100 less annually per employee on health insurance. That gap has increased slightly in the last 4 years. The most glaring and shameful result of this is that 160,000 full-time, year-round, permanent Federal employees have no health insurance. And when surveyed by OPM as to why they do not participate in FEHB, they say that they can't afford it.

This fact represents the failure of both FEHB as well as the Nation's health care delivery system, of which FEHB is just a small part.

So it is in this context that we question the President's goal to leave Federal employees no worse off as a result of reform.

The health insurance benefits provided to Federal employees must be improved under reform, not only for those who cannot af-

ford coverage currently but also for those who need more comprehensive and more affordable coverage than they currently have.

Once the principle is accepted that elimination of FEHB in favor of participation in regional health alliances establishes part of the Health Security Act should leave Federal employees better off, the difficult task of specifying the formula for improving that benefit begins.

The question becomes how to take a group of 9 million active Federal employees, annuitants, and their dependents who are currently enrolled in more than 300 different plans, with various premiums and benefits, and put them into a new system with at least 153 new plans and make them better off.

At a minimum, AFGE's goal is to make certain that Federal employees pay no more than they do now and to make certain that their benefits are at least equivalent to what they currently receive. To accomplish this, we must consider both premium contributions and benefit packages, which are different from the minimums proposed in the President's bill.

To begin, we must arrive at a definition of what Federal employees currently receive. It is not enough to make certain that the dollar value of the Government's contribution does not decline. Our goal for reform is that, through cost controls, the elimination of cost sharing, and reallocation of resources, each health care dollar will be able to purchase more. What then should be the standard against which we measure any new plan and call it a good deal for Federal employees as a group?

The rhetoric of the administration as it promotes its plan is that it will lower health care costs for corporations that currently provide comprehensive benefits, making possible an end to the stagnation in wages that working people have suffered over the last 15 years as health care costs have spiralled.

The Federal Government, as an employer, will also see its costs fall. But as the Health Security Act is written, any savings under the new system would apparently accrue to the Government.

AFGE wants to make certain that if real costs do decline, Federal employees benefit from those savings.

Given the complexities in defining the prevailing FEHB benefit, AFGE believes that Federal employees should be provided the set of benefits in FEHB's 1994 Blue Cross/Blue Shield's standard option plan, with the government paying 90 percent of the premium for such benefits.

The differences between these benefits and those offered in the Health Security Act's standard packages for the high cost-sharing option must be made available in a supplemental package.

The Government's total contribution would then be calculated on an additive basis as the sum of 90 percent of the weighted average premium in a given standard alliance package and the 90 percent of a community-rated premium for a supplemental package, which would bring Federal employees' coverage up to the level of 1994 Blue Cross and Blue Shield standard option. In areas where the benefits in the President's standard package are superior to those in the Blue Cross package, Federal employees should receive the higher benefit.

The types of benefits which would be included in the supplemental package would be 100 percent inpatient hospital care with no limit on the number of days and no per admission deductible if the hospital were in a plan's network, and 100 percent for such care after a $250 per admission deductible, if the hospital were outside the network.

Fee schedule allowances for adult dental care and lower annual out-of-pocket maximums would also be included. There are other specific benefits and coverage levels included in the Blue Cross plan that vary from the proposed standard package which AFGE would be happy to provide to the committee.

The final explicit safeguard which AFGE believe needs to be included in the legislation involves the impact of variations in premiums by locality.

In the short run, we anticipate that there will be large differences in local alliance premiums, based on the risk characteristics of local populations. Areas with large concentrations of people who are elderly, poor, underserved, are likely to have premiums which could result in Federal employees having to pay more than they currently do in the FEHB's national plans, despite the seeming improvement in the cost-sharing formula.

Ten percent of a higher premium in, say, Washington, DC, may be higher than 28 percent of the current FEHB experience-rated premium, which applies equally to Federal employees throughout the Nation. The principle of protecting Federal employees so that none is worse off as a result of reform will require special coinsurance rates in these cases.

There was an awkward political problem regarding Federal employees' health benefits under the Clinton plan. The so-called standard benefits package proposed for all Americans is inferior to that provided to Congress, the executive branch, and members of the Federal judiciary through FEHBP. If the plan is good enough for us, why, then, is it not good enough for every one else? The political symbolism is difficult to ignore, but the problem is solved by acknowledging that the standard package represents only a minimum.

AFGE has never supported the idea of maintaining FEHB as a separate, private program once national health care reform was enacted.

On the contrary, we have always supported universal coverage and participation, including Federal employees. In fact, we do not support the right of large employers to form their own corporate alliances outside the community-based alliance system, because we think this allows them to be freeriders, taking advantage of the community's health care infrastructure without having to pay the community-rated premiums which will reflect its cost.

AFGE has no affinity for the FEHBP system, and we believe that the Clinton plan holds the potential to be a vast improvement. But we do not want Federal employees to suffer in order to maintain the pretense that the President's reform plan will mean everyone in America will have the same coverage.

The standard benefits package must be seen as a minimum, or floor. It reflects the fiscal constraints on the Federal Government and the competitive restraints on some businesses. Ideally, every-

one would have more comprehensive benefits than are specified in the floor, just as everyone would be paid more than the minimum wage. But a variety of political and economic factors have forced the President to be more modest in his benefit package than any of us might have preferred.

Federal employees currently receive health benefits which are superior to those in the standard package, and we are not prepared to receive less under reform. We believe that guaranteeing the benefits set forth in the 1994 Blue Cross and Blue Shield FEHBP plan, with a Government contribution to the premiums set at 90 percent, is an appropriate solution.

This concludes my testimony. And I would be happy to answer any questions at the time everyone else completed their testimony.

Mr. McCLOSKEY. Thank you, Mr. Sturdivant.

[The prepared statement of Mr. Sturdivant follows:]

PREPARED STATEMENT OF JOHN STURDIVANT, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. Chairman and members of the Committee, my name is John Sturdivant and I am the National President of the American Federation of Government Employees, AFL–CIO. On behalf of the more than 700,000 Federal and District of Columbia employees our union represents, I thank you for the opportunity to testify here today. AFGE has been active for decades in the effort to reform our nation's health care system to one which resembles Canada's single payor format. It is therefore a pleasure to come before you today to engage in discussion over how to improve an already excellent blueprint for guaranteeing every American high-quality and affordable health insurance.

AFGE would like to congratulate President Clinton for keeping his promise to make national health care reform a top priority of his administration. The question of the day is no longer whether we need reform, but rather what is the best approach to reform. The President deserves credit not only for this, but also for keeping the principles of universal coverage and stringent cost containment at the heart of his proposals.

AFGE has been highly critical of the Federal Employees Health Benefits Program (FEHBP). Despite the fact that the approach to providing access embodied in President Clinton's plan appears to be modeled loosely on the FEHBP, we believe that it is structurally superior to FEHBP in many ways. In particular, it avoids risk segmentation by specifying a minimum standard benefit package, it avoids cost-shifting by providing universal coverage, and perhaps most important, it provides genuine cost containment through global budgeting and coordinated allocation of health care technology.

The most critical failing of FEHBP from the perspective of employees has been inadequate employer financing. In 1989, the Congressional Research Service (CRS) conducted a comprehensive analysis of FEHBP and found that on average, the federal government spent $1,100 less annually per employee on health insurance coverage than the typical large private sector employer. Despite the fact that some large corporations have increased out-of-pocket costs for their employees in recent years, that gap has increased slightly in the last four years. The most glaring and shameful result of the federal government's inadequate contribution to health insurance benefits for its employees is that according to the OPM's Central Personnel Data File (CPDF), 18.6 percent of Federal employees who are eligible to participate in FEHBP do not. Almost half of these federal employees do not have health insurance coverage from another source.

To put it plainly: In 1990, 160,000 full-time, year-around, permanent Federal employees had no health insurance, and when surveyed by OPM as to why they did not participate in FEHBP, they replied that they could not afford it. In testimony last week, OPM Director Jim King indicated that the number of full-time federal employees without any health insurance coverage had grown to 300,000.

According to President Clinton's own numbers, 30 million of the 37 million Americans who have no health insurance are employed. The sad fact is that 7 percent of the federal government's own career workforce has no health insurance because they lack the means to pay for it. This fact represents the failure of both the FEHBP as well as the nation's health care delivery system, of which FEHBP is just

a small part. So it is in this context that we question the President's goal to leave federal employees "no worse off" as a result of reform. The health insurance benefits provided to federal employees must be improved under reform, not only for those who cannot afford coverage currently, but also for those who need more comprehensive and more affordable coverage than they currently receive.

Once the principle is accepted that elimination of FEHBP in favor of participation in regional health alliances established as part of the Health Security Act should leave federal employees better off, the difficult task of specifying the formula for improving their benefit begins. The question becomes how to take a group of 9 million active federal employees, annuitants, and their dependents, who are currently enrolled in more than 300 different plans with various premiums and benefits, and put them into a new system with at least 153 new plans (at 3 per state plus the District of Columbia) and make them better off?

The answer would be clear and simple if the standard benefits package were truly comprehensive and fully financed by employers or through the federal tax system. But the President has not chose this road.

At a minimum, AFGE's goal is to make certain that federal employees pay no more than they do now, and to make certain that their benefits are at least equivalent to what they currently receive. To accomplish this, we must consider both premium contributions and benefit packages which are different from the minimums proposed in the President's bill.

To begin, we must arrive at a definition of what federal employees currently receive. It is not enough to make certain that the dollar value of the government's contribution does not decline; our goal for reform is that through cost controls, the elimination of cost-shifting, and reallocation of resources, each health care dollar will be able to purchase more. Thus we must define both the current cost of FEHBP, as well as the health benefit package which is available through the program.

There is no straightforward way to define the prevailing benefits or costs in FEHBP. Different plans have different benefits and premiums. The premiums charged in Blue Cross and Blue Shield's High Option have been skewed by the risk characteristics of enrollees so much that there is a nearly 250 percent variance between the actuarial value of the plan's benefits and its premiums. Some plans have the "best" benefits, some have the "best" price relative to benefits (but poor benefits), and some have the "best" price. The truth is there is no "best" plan in FEHBP. What then should be the standard measure, the standard against which we measure any new plan and call it a good deal for federal employees as a group?

Blue Cross Blue Shield Standard Option has the largest concentration of FEHBP enrollment, but it does not have the most comprehensive benefits. Worse, its benefits change from year to year. There is no strict floor on the benefits plans must provide to participate in FEHBP; OPM may require coverage for a category of treatment, but they do not make requirements about the rate or form of indemnity the insurer must provide. AFGE will not worry about the fact that there are some people enrolled in FEHBP who have very low-cost plans with minimal benefits: they will likely pay more as a result of reform, but they will also receive better benefits. But we are concerned with protecting the benefit levels of those in plans with very high benefits. The cost of the benefits included in these "high" option plans is reflected in the government's premium contribution to every plan in FEHBP, so they can not be considered as exceptions or outlyers which do not affect the prices of other plans. The concentration of high risk individuals in particular plans also allows other plans to charge lower premiums than they could in a system free of risk segmentation. Thus both the premiums offered and the benefits charged in all plans which enroll federal employees must be considered in defining the current FEHBP benefit.

Dr. Judith Feder, who testified along with OPM Director Jim King before this committee last week, claimed that the actuarial value of the benefits in the President's standard package was roughly equivalent to the average set of benefits offered in FEHBP plans. The differences, she said, were in the types of services covered, with the President's plan placing relatively higher priority on preventive care for both adults and children. Representative Eleanor Holmes Norton (D–D.C) questioned whether the actuarial value of hospitalization coverage was comparable to that of preventive care, and Dr. Feder implied that it was, but evaded the question by arguing that if federal enrolles chose "low-cost sharing" plans, i.e. HMOs, the problem became moot.

AFGE considers this a crucial issue which cannot be avoided: Federal employees should not be forced to concede complete coverage for hospitalization in order to gain eligibility for prepaid preventive care. And the price of having both should not consign one to the restrictions of an HMO. The current system, with all its flaws, provides a majority of participants with both 100 percent hospitalization, and a vari-

ety of preventive services for both children and adults, including dental care. Moreover, the majority of FEHBP participants receive these benefits through fee-for service plans which they have chosen over other "lower cost-sharing" formats.

AFGE believes that the contention that comprehensive preventive service coverage represents a benefit with roughly equivalent actuarial value to the last 20 percent of hospitalization coverage is specious. We request that some attempt be made to validate this assertion with empirical data before federal employees are denied what we consider enormously valuable hospitalization coverage. Our own experience suggests that the data will refute this claim.

Federal employees want national health care reform, but we are firm in our belief that the advantages positive reform will bring, such as cost containment, universal coverage, rational allocation of resources, etc.; will allow the federal government to provide federal employees with superior benefits and lower overall costs than currently exist under the FEHBP. Indeed, Dr. Feder, speaking for the Administration at last week's hearing before this Committee, acknowledged that the government expects to spend less on federal employee health benefits as a result of reform. The rhetoric of the Administration as it promotes its plan is that it will lower health care cost for corporations that currently provide comprehensive benefits, making possible an end to the stagnation in wages that working people have suffered over the last 15 years as health care costs have spiraled. The federal government, as an employer, will also see its costs fall. But as the Health Security Act is written, any savings under the new system would apparently accrue to the government. AFGE wants to make certain that if real costs do decline, federal employees benefit from those savings. Given the complexities in defining the "prevailing" FEHBP benefit, AFGE believes that federal employees should be provided the set of benefits in FEHBP's 1994 Blue Cross and Blue Shield standard option plan, with the government paying 90 percent of the premium for such benefits. The difference between these benefits, and those offered in the Health Security Act's standard package for the "high cost-sharing" option must be made available in a supplemental package. The government's total contribution would then be calculated on an additive basis, as the sum of 90 percent of the weighted average premium in a given standard "alliance" package, and 90 percent of a community-rated premium for a supplemental package which would bring federal employees' coverage up to the level of the 1994 Blue Cross and Blue Shield standard option. In areas where the benefits in the President's standard package are superior to those in the Blue Cross package, federal employees should receive the higher benefit.

The types of benefits which would be included in this supplemental package would be 100 percent inpatient hospital care with no limit on the number of days and no per admission deductible if the hospital were in a plan's network, and 100 percent for such care after a $250 per admission deductible, if the hospital were outside the network. Fee schedule allowances for adult dental care and lower annual out-of-pocket maxima would also be included. There are other specific benefits and coverage levels included in the Blue Cross plan that vary from the proposed "standard" package which AFGE would be happy to provide to the Committee.

The final explicit safeguard which AFGE believes needs to be included in the legislation involves the impact of variations in premiums by locality. In the short run, we anticipate that there will be large differences in local alliance premiums based on the risk characteristics of local populations. Areas with large concentrations of people who are elderly, poor, under-served, etc. are likely to have premiums which would result in federal employees having to pay more that they currently do in FEHBP's national plans, despite the seeming improvement in the cost-sharing formula. Ten percent of a higher premium in, say, Washington, D.C., may be higher than 28 percent of the current FEHBP experience-rated premium which applies equally to federal employees throughout the nation. The principle of protecting federal workers so that none is worse off as a result of reform will require special coinsurance rates in these cases.

The benefits in the Blue Cross and Blue Shield plan, along with supplemental cost-sharing adjustments in areas with extraordinarily high local costs, would bring federal compensation closer to that offered by large private sector employers. The government/employer contribution would continue to be lower, both in percentage and nominal terms, but the benefits would be closer to parity. AFGE has made the argument repeatedly, in the context of salaries, health benefits, and retirement benefits, that compensation parity with non-federal employers is vital to the government's effort to recruit and retain highly qualified and highly motivated workers.

The reinventing government initiative, which AFGE has supported, is based on the belief that a workforce that is smaller, but more highly "valued" will succeed in regaining the public's trust and respect. Federal workers who receive better pay and benefits, more training opportunity, more responsibility, more control over their

work will be motivated in a variety of ways to create a government that is more efficient and responsive to the people it serves. AFGE shares these goals with the Clinton administration, and we believe that improving federal employees' health care coverage at the same time that national health care reform is undertaken will go far in helping to accomplish them.

The Problems of the District of Columbia

AFGE represents over 55,000 residents of the District of Columbia, who work for both the federal and District governments. We are gravely concerned about the disadvantages we foresee for the City of Washington if health alliances are established on a state-by-state basis. The risk pool for Washington is similar to other large urban centers, and will include an extraordinarily high proportion of people who represent high health care risks: the poor, substance abusers, those exposed to violence, and previously uninsured people whose health status has suffered because they have not had regular access to preventive care. Washington, D.C. has the nation's highest per capita rate of both AIDS and HIV infection. It has the nation's highest infant mortality rate, and one of the highest homicide rates. Other urban areas with similar populations will benefit from inclusion in an alliance area which brings wealthier and healthier suburban residents together in a more diverse pool. But Washington does not have that advantage.

These issues are of particular concern to AFGE because federal and District of Columbia employees represent a significant majority of the insured population of Washington. We will feel the direct impact of the District's disadvantages.

There is no incentive in the President's bill for either Virginia or Maryland to include a high-cost urban area like Washington, D.C. in their state alliances, even though they would be permitted to do so. Although agreements will undoubtedly be made which will allow residents of the Washington suburbs to utilize the city's excellent health care facilities, the problem remains that Washington's residents will be disadvantaged relative to those in other urban areas, as well as those who work there but live in its suburbs.

Without some provision of subsidies to compensate for the District's disadvantages, all of the social and economic problems which make the Washington population high-risk to begin with will be exacerbated. Since individuals will enroll in plans based on where they reside as opposed to where they work, District residents will be less attractive to employers because the premiums for their care will be higher than those of suburban residents. Unemployment and poverty in the District will increase. Firms will find it economical to locate in the suburbs rather than the city, and residents who can afford to will also be inclined to leave. The attendant decreases in tax revenues will also exacerbate the City's problems, causing continued funding problems for public schools and other public services.

Other urban areas which include more than one state will face similar difficulties, but the fact that the District is not a state makes it uniquely vulnerable, especially in terms of the restrictions in taxing authority it faces. AFGE believes that in order to avoid the devastating fallout which would result from implementation of the President's bill as it is written, Washington, DC will need either direct subsidies for its population, or the surrounding states will need financial inducements to include Washington residents in their alliances.

Because of the high concentration of federal employees living in the District, the high premiums which would be charged in Washington if it remains isolated are of concern to all federal employees. The local boundaries drawn for the locality pay system, which reflect commuting patterns, stretch from Baltimore to Saint Mary's County in Maryland to Prince William County in Virginia. This "community" will be paid on the same basis, but is likely to face vastly different health insurance premiums, unlike in the current system. AFGE urges the committee to address the unique disadvantages federal employees living in Washington, DC face.

The Politics of Inclusion in Local Alliances

There is an awkward political problem regarding federal employees' health benefits under the Clinton plan: the so-called "standard benefits package" proposed for all Americans is inferior to that provided to Congress, the Executive Branch and members of the Federal Judiciary. If the plan is not good enough for us, why then is it good enough for everyone else? The political symbolism is difficult to ignore. But the problem is solved by acknowledging that the "standard" package represents only a minimum.

AFGE has never supported the idea of maintaining FEHBP as a separate, private program once national health care reform was enacted. On the contrary, we have always supported universal coverage and participation, including federal employees.

In fact, we do not support the right of large employers to form their own "corporate alliances" outside the community-based alliance system because we think this allows them to be free-riders, taking advantage of the community's health care infrastructure—medical education, hospitals, the benefits of subsidized medical and pharmaceutical research, etc.—without having to pay the community rated premiums which will reflect the costs of supporting this infrastructure.

AFGE has no particular affinity for the FEHBP system, and we believe that the Clinton plan holds the potential to be a vast improvement. But we do not want federal employees to suffer in order to maintain the pretense that the President's reform plan will mean everyone in America will have the same coverage. AFGE would likely have supported such a plan, but that is not what the president has proposed. Thus the standard benefits package must be seen as a minimum, or floor. It reflects the fiscal constraints on the federal government and the competitive restraints on some businesses. ideally, everyone would have more comprehensive benefits than are specified in the floor, just as everyone would be paid more than the minimum wage. But a variety of political and economic factors have forced the President to be more modest in his benefits package than any of us might have preferred.

Federal employees currently receive health benefits which are superior to those in the standard package, and we are not prepared to receive less under reform. We believe that guaranteeing the benefits set forth in the 1994 Blue Cross and Blue Shield FEHBP plan, with a government contribution to the premium set at 90 percent, is an appropriate solution. It would be a slight improvement over the *status quo* for the majority of federal employees.

CONCLUSION

AFGE supports President Clinton's prodigious effort to solve our nation's health care crisis in a way that preserves what is good and eliminates what is wrong. But we will not support the bill if it causes a reduction in health benefits or an increase in costs for federal employees. We consider the general approach to be fair, and are hopeful that if enacted, it will succeed in providing universal coverage, meaningful cost controls, and progressive financing. This concludes my testimony, and I will be happy to answer any questions you may have.

Mr. MCCLOSKEY. Mr. Tobias.

Mr. TOBIAS. Thank you very much. We really appreciate the opportunity to testify on this incredibly critical issue to Federal employees and to the Nation at large. And we appreciate the role that this committee has taken in so clearly stating last week the issues concerning Federal employee health benefits to the administration and to OPM. We all know the problems with the existing FEHB system.

The problem of high administrative costs, the problem of adverse selection, people with certain illnesses choose a plan because of that illness, and then subsequently drive the plan out of business, or adverse selection which leads to competition among the plans to craft a plan which discourages the sick from applying. We are all familiar with the fact that premiums that are charged in the FEHB system do not reflect the value of the benefits provided.

We appreciate the courage of the President in putting the issue on the public agenda for consideration. It is important that every American citizen be provided with health care and be freed from the terrible fear of needing health care and facing the health care industry without insurance. But I urge this committee to consider several important issues before it decides whether to fold the FEHB Program into the national plan.

First, 86 percent of retirees and 62 percent of active employees are currently in plans which provide 100 percent in-patient hospitalization and emergency services. The administration plan would pay 80 percent, not 100 percent.

Most FEHB plans offer adult dental care, but the administration plan would not make even routine preventive dental care available until the year 2001.

Most FEHB plans offer coverage for prescription drugs.

For example, Blue Cross/Blue Shield offers coverage after a $50 deductible and 20-percent copayment. The administration requires a $250 deductible.

Finally, the administration proposal states it will pay 80 percent of premiums. But as Congresswoman Norton asked last week, 80 percent of what? Eighty percent of what? The administration proposal may cost Federal employees more, significantly more, than they currently pay.

I urge that the administration plan treat Federal employees no different than it treats private sector employees. Existing benefits and premiums in collectively bargained agreements in effect as of January 1, 1994, remain in effect for 10 years without any tax consequences. No less should be provided to Federal employees through the creation of supplemental benefits paid for by the Federal Government.

The current administration proposal guarantees benefits only to current retirees. We ask that the same guarantees be provided to existing employees and to future retirees.

We ask that the administration proposal be evaluated in terms of what makes good sense in the context of an employer/employee relationship.

The administration has opted to allow private sector employees in the context of an employer/employee relationship to maintain existing benefits at no cost increase. No less should be provided to employees of the Federal Government.

We believe that it is critically important that this plan be evaluated not only in the context of health care for this Nation but health care for employees who work for the Federal Government.

Can employees be attracted and retained through the kind of program that is being offered? We can't expect to attract and retain a viable Federal work force while at the same time increasing premiums and decreasing benefits.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Tobias follows:]

PREPARED STATEMENT OF ROBERT TOBIAS, NATIONAL PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION

Chairman Clay, Members of the Committee: I am Robert M. Tobias, National President of the National Treasury Employees Union (NTEU). On behalf of the 150,000 federal workers represented by NTEU, I appreciate the swiftness with which you have convened this important hearing today. NTEU is anxious to share with the Committee our views on the President's proposal to reform the Nation's health care system.

As you know, Mr. Chairman, I have appeared before the Post Office Committee on numerous occasions in the past several years to share NTEU's concerns over the operation of the Federal Employees Health Benefits (FEHB) program. The problems with the FEHB system have been well documented. The administrative costs of operating the program continue to run well above acceptable levels. Risk segmentation plagues the program forcing plans to compete for enrollees not through efficiency and reduced costs, but by attempts to repel those potential enrollees who might require intensive health care. And premiums continue to be little reflection of the value of the benefits offered by a plan. The Administration's national health care proposal includes several proposals that we have long advocated for FEHB—in particular, a standardized benefit package and controls on premium increases. How-

ever, there are several elements of the proposed package with which we disagree. I will outline the issues that I believe must be resolved before the question of whether or not the FEHB program should be folded into a national plan can even be addressed.

There is no question that the President's plan is a step in the right direction to providing health coverage to the millions of American workers and families who lack even the most basic protection against the costs of catastrophic illness. The President and Mrs. Clinton deserve our praise for the grueling months of work that have culminated in the presentation of the Health Security Act to Congress.

The FEHB program is the Nation's largest employer-sponsored health care plan providing health insurance protection to over 9 million individuals across the globe. It is noteworthy that FEHB premiums have risen at a lower rate than private sector health care plan premiums over the last decade and its managed competition approach to health care has been widely described as an example of the efficient provision of health care benefits. While far from perfect, I am not convinced that enacting a national health care plan should necessarily include the dismantling of the FEHB program, or that this is in the best interests of federal employees and retirees. Many questions remain to be answered before this decision can be reached.

According to the Office of Personnel Management (OPM), the average overall premium increase for FEHB plans for the 1994 contract year will be 3 percent. Moreover, fully 40 percent of employees and retirees enrolled in an FEHB program will see decreases from their 1993 premiums. These are the type of statistics that proponents of the Health Security Act hope to achieve in the out years. The FEHB program is achieving these results now. As the Chairman pointed out while receiving testimony on this topic from OPM last week, with appropriate changes, the FEHB program could be a model health care plan.

I am relieved that the Administration has concluded that the FEHB should not be folded into a national health care plan until 1998 when all state alliances are expected to be operational. However, it is particularly unsettling that the Administration proposal would allow corporate alliances to be formed by companies with 5000 or more employees, yet, the federal government, with over 2 million employees, would be expressly prohibited from exercising this option. Unless the issues that I will outline here today are resolved, I question whether or not the FEHB program should be dismantled and folded into a national plan at all.

The proposed benefit package under the Health Security Act is lacking in three major areas where federal employees and retirees currently enjoy comprehensive coverage. Fully 86 percent of federal retirees and 62 percent of employees opt for fee for service plans within the FEHB. The vast majority of these fee for service options cover 100 percent of the cost of inpatient hospitalization and emergency services. The proposed benefit package would only cover 80 percent of these costs—leaving enrollees vulnerable for up to 20 percent of the price of this care. Given the steep cost of inpatient hospitalization, this represents a significant benefit reduction. Even though the proposed legislation caps out of pocket expenses with a catastrophic limit of $1500 dollars for individuals and $3000 dollars for families, a great many more individuals would reach this annual cap than is currently the case as a direct result of the added exposure to inpatient hospitalization expenses.

In addition, the proposed benefit package would not provide coverage for routine preventive adult dental care until the year 2001. Conversely, most FEHB plans currently offer dental coverage ranging from routine preventive to comprehensive care depending upon the plan chosen.

Third, the Administration package is deficient in the coverage it would offer federal employees for prescription drugs. Many FEHB plans make prescription drug coverage available without deductible through the use of prescription drug cards or mail order programs. The most popular FEHB plan, the Blue Cross-Blue Shield Standard Benefit Plan offers drug coverage after payment of a $50 deductible and 20 percent copayment, or through their mail order program for a $12 dollar copaymennt without any deductible. By comparison, the suggested benefit package would require federal workers to pay the first $250 dollars of their prescription needs before it would begin coverage of 80 percent of the cost of necessary drugs.

On the other hand, the proposed mental health benefits package is more generous than that available in the FEHB, as is the coverage of preventive care services without liability for copayment. While the addition of these items makes the proposed benefit package appear to be actuarially similar to the standard FEHB package, I do not believe that 100 percent hospitalization coverage, adult dental care and prescription drug availability without deductible are benefits that should be traded off. At a minimum, the federal government, as employer, should be required to contribute towards supplemental benefit plans for federal workers covering the FEHB benefits excluded from the Administration's proposed package.

As you know, the Administration's legislation specifically requires that the Office of Personnel Management both offer and contribute to supplemental benefit packages only for current federal retirees. This is a major flaw in the package. Current retirees are described as those already retired by December 31, 1997. These individuals would continue to receive the additional health insurance protections they currently receive in their FEHB plans. The Administration has explained that they believe current retirees feel entitled to the benefits they are receiving. This is no less true for active employees and future retirees who I would wager feel equally entitled to the level of protection they now have in the FEHB program. Why would a federal retiree who, for example, might have worked for the federal government for ten years before retiring feel more of an entitlement than an active employee who, although not yet retired, has completed 30 years of loyal service?

For active employees and future retirees, the Health Security Act would only give OPM the authority to offer and pay for supplemental benefit packages. Without benefit improvements in the areas I have outlined, or a mandate that OPM offer and contribute to supplemental benefit packages for active employees and future retirees as well, this constituency will be significantly less well off under this legislation.

Concerns have also arisen regarding the premiums federal employees may be required to pay to obtain coverage through their regional alliances rather than through the FEHB program. The premium data the Administration has made available is sketchy and it is difficult to draw any accurate comparisons between the two programs. The federal government currently pays an average of 72 percent of the FEHB premium for its employees. The Health Security Plan dictates that employers would be responsible for paying 80 percent of the cost of the average priced health insurance plan in a region for their employees. While on its face, this would appear to be an improvement, too little is known to reach more than a preliminary estimate of the costs an employee might incur. As I believe Subcommittee Chairwoman Norton observed at last week's hearing, the question is 80 percent of what?

Under the Health Security Act, the 80 percent employer premium appears to be calculated on the basis of 80 percent of the average premium in an alliance weighted by enrollment in each plan. The average cost plan available may be a managed care or preferred provider type of organization while the higher cost plan may be a fee for service option and the lowest cost plan is likely to be a health maintenance organization option. If this is the case, a federal worker choosing a fee for service option—as the majority of federal workers do now—may well find that the employer's 80 percent payment pegged to the average cost plan may translate into less actual dollar coverage than he or she currently receives with the federal government's current 72 percent contribution. I was particularly concerned that in response to questions concerning premiums before this Committee last week, Judith Feder, Principal Deputy Assistant Secretary at HHS, only stated that if an individual chooses a low cost plan, it will compare favorably to FEHB. The unfortunate implication here may be that the popular fee for service options may be prohibitively expensive and out of reach for some federal workers under the regional alliance system of health care. I urge this Committee to carefully review these issues.

These premium questions become even more important if federal workers find they must purchase supplemental coverage in order to protect themselves from exposure to inpatient hospitalization, dental and prescription drug expenses. Additional premiums for this coverage—coverage most federal workers enjoy now—may push the total premium cost these workers face considerably above the levels they pay now.

In addition, if this portion of the Health Security Act is not altered, federal workers will be significantly less well off than their private sector counterparts. Private sector employees will continue to benefit from collectively-bargained benefits, premium cost sharing and copayments in excess of the standard benefit packages. Furthermore, benefits in effect on January 1 of this year will continue to be excluded from employee income for 10 years. Federal workers are at a distinct disadvantage in this area because we are not permitted to collectively bargain for pay or benefits. It is imperative to this Union that absent the benefit improvements necessary to equate the Administration's package with that widely available in the FEHB, the Office of Personnel Management must offer and contribute toward supplemental benefit packages for federal workers. We have been told by the Administration all along that federal workers would not be worse off as a result of enactment of national health insurance. Mandated supplemental benefit packages will put teeth in that statement.

It has been NTEU's position from the beginning that we will support no system that results in fewer benefits or greater out of pocket costs for the federal community. We continue to stand by our commitment to this bottom line. If the issues I have identified concerning the least acceptable benefit package and employer-em-

ployee premium sharing are not addressed either through improvements in the Administration's national health care proposal or through the provision of supplemental benefit packages with OPM contributions, NTEU will have no choice but to support the continuation of the current FEHB program and focus our efforts on making the needed improvements to the program.

I thank you again Mr. Chairman for this opportunity to share our thoughts. We look forward to working with the Post Office and Civil Service Committee on these matters. I would be happy to answer any questions.

Mr. MCCLOSKEY. Mr. Carter, president of the National Association of Retired Federal Employees.

Mr. CARTER. Mr. Chairman, I am Charles W. Carter, president of the National Association of Retired Federal Employees, better known as NARFE. I appreciate the opportunity to appear before you today on behalf of NARFE's 150 million members. Correct that, sir. It is over a half a million. Nothing like inflating the numbers.

Mrs. MORELLA. We thought there was some kind of buyout that took place.

Mr. CARTER. I would like to stop right here and say to Congresswoman Morella that we, indeed, thank her for her support; and our membership, I know, has been in touch with you. And I appreciate that, as many members on the panel.

We have 450,000 members nationwide, and they are deeply concerned. We are committed to national health care legislation. We support that.

First, we want to take this opportunity to thank Chairman Clay for helping the administration to focus on the concerns Federal employees and retirees have with this legislation.

Due to his intervention, the administration has agreed to postpone transferring Federal Employees Health Benefits Program enrollees into the State health alliance system until 1998 when such alliances are established in all 50 States.

We know that you were also instrumental in ensuring that individuals who retire from Federal service by 1998 will continue to receive the same level of health care at the same prices. Your intervention on behalf of Federal workers and retirees improves the President's health reform bill, and we now have a better starting point for our consideration of this legislation.

From the beginning, NARFE has supported the President's efforts to provide universal coverage to all Americans, contain health care costs, and eliminate needless paperwork and administrative waste. We have been particularly pleased with the administration's decision to include home- and community-based long-term care, and Medicare prescription drug benefits, medical health benefits, and health coverage from early retirees.

Let me make clear NARFE's conviction, that without these benefits, health care legislation will neither be comprehensive nor reformed.

NARFE applauds the administration's decision to postpone the transfer of FEHBP enrollees into the alliance system and to ensure present level coverage and costs for current retirees. But we are still troubled about the proposed elimination of the plan, and we continue to have concerns about health care coverage and the costs for active Federal employees and the future retirees under the President's bill.

I have some more prepared comments here, Mr. Chairman. However, my colleagues have basically stated how I feel. The comments that we have submitted for the record have been accepted with attachments.

I would like to just touch on something else that I feel strongly about, that having worked for the Federal Government and now retired. I continue to see this effort to conquer and divide. And, for that reason, I want to assure you that we are as deeply concerned about the active employees as we are about retirees. They are our future members, and we are concerned about them and the treatment that they receive.

We enjoyed focusing our attention with the government on many things. We hope—and we have seen these things improve. And we hope that they will continue to improve. However, we will not support this conquer and divide situation. It seems to be a big trend, and we are going to support active employees on all issues in regard to this health care legislation and many, many other issues that affect us.

What I am deeply concerned about and hasn't been mentioned—or no one seems to talk about or want to put on the table. Doctors used to be healers. Now they become businessmen. And since that has happened, we have seen the introduction of profiteering, greed, and corruption. We only need to look to the private sector when you want to start setting examples and making comparisons. Look at the fact that they do not have cost containment and controls over there. OPM has an excellent program.

The record has clearly established that cost controls are working in FEHBP. I picked up the paper the other day and I read that Maryland owes $116 million in overdue health fees to the State of Maryland, to keep that plan effective. This is not happening in the Federal Government. It is controlled, so we don't see those things.

I hear there is going to be great cost savings from reinventing the Government. I picked up the paper yesterday and read that Vice President Gore said $9.1 billion would be saved. When we get down to realistic figures, $305 million will be more accurate.

I don't like being put on the line, seeing retirees pitted against the younger workers. We need that support so that our costs are not severely escalated. If you seperate employees from retirees; it is the old conquer and divide, the young against the old. Again, that is wrong.

As Mr. Tobias has said, we come here to work for the Government; we look for job security; we look for adequate retirement; we look for health care and benefits. These are the things why we take lower wages and work for the Government. I would hate to see this all destroyed.

I wish Congressman Clay was here, because he gave a speech some years back, and I thought it was absolutely beautiful, when he said, they came and they handed out some yellow, blue, and red badges; and when they came to gather up these badges off those persons they had handed them to, there were none left by the time they got down to the red badges.

Well, I see the yellow badges have been handed out to labor, and yesterday's vote on NAFTA clearly demonstrates they have come and taken labor away.

The blue badges, I feel, have been handed out to the retirees and to the active employees. And if we lose this issue, if we lose some of the other benefits that are going to destroy good government, we are going to be taken away.

I can see the red badges being handed out to Congress. And when they implement term limitation, I am sure they are going to come to take you away and we are not going to be here to help you, because we are going to already be gone.

We would like to continue our partnership with Congress. We think it is a good partnership. You are our employer. We look forward to you to treat us right. If you are going to throw us to the wolves and put us in with private sector, then give us all the benefits, allow us to have the same rights as General Motors, allow us to have the same rights as the postal worker. We have only asked for fairness. We have never been greedy. We don't want to become needy.

I thank you. And I will be pleased to answer any questions that you have.

Mr. McCLOSKEY. Thank you, Mr. Carter, for a very forthright statement.

[The prepared statement of Mr. Carter follows:]

PREPARED STATEMENT OF CHARLES W. CARTER, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Mr. Chairman, I am Charles W. Carter, President of the National Association of Retired Federal Employees (NARFE). I appreciate the opportunity to appear before you today on behalf of NARFE's one-half million members to comment on President Clinton's comprehensive health care reform legislation, the Health Security Act of 1993.

We first want to take this opportunity to thank you, Chairman Clay, for helping the Administration to focus on the concerns federal employees and retirees have with this legislation. Due to your intervention, the Administration has agreed to postpone transferring Federal Employee Health Benefit Program (FEHBP) enrollees into the state health alliance system until 1998 when such alliances are established in all 50 states. We know that you were also instrumental in ensuring that individuals who retire from federal service by 1998 will continue to receive the same level of health care at the same price. Your intervention on behalf of federal workers and retirees improved the President's health reform bill, and we now have a better starting point for our consideration of this legislation.

From the time the President first announced his intention to reform our nation's health care system, NARFE has supported his efforts to provide universal coverage to all Americans, contain health care costs, and eliminate needless paperwork and administrative waste.

We are particularly pleased with the Administration's decision to include home and community based long term care, a Medicare prescription drug benefit, mental health benefits and health coverage for early retirees. However, we are disturbed by reports that these provisions are in danger of being diluted or removed from the President's bill. Let me make clear NARFE's conviction that without long term care, prescription drug and mental health benefits and early retiree coverage, health care legislation will be neither comprehensive nor reformed.

NARFE applauds the Administration's decision to postpone the transfer of FEHBP enrollees into the alliance system and to assure present level coverage and costs for current retirees. But we are still troubled about the proposed elimination of FEHBP. And we continue to have concerns about health care coverage and costs for active federal employees and future retirees, under the President's bill.

For instance, most FEHBP plans pay 100 percent of emergency services and inpatient hospitalization costs, while active employees and future retirees would only be covered for 80 percent of these costs under the minimum standards mandated for alliance plans in the Administration's bill.

The proposed prescription drug benefit also falls short. The present FEHBP-provided Blue Cross/Blue Shield preferred pharmacy prescription drug benefit requires enrollees to pay a $50 annual deductible and a 20 percent co-payment per prescrip-

tion. The Administration's bill would require the same 20 percent co-payment, but federal employees and future retirees would be required to pay a deductible $200 higher than they presently pay under the Blue Cross/Blue Shield plan. The legislation's restrictive dental coverage also falls short of that available under FEHBP. This will result in a benefit cut for the majority of today's FEHBP enrollees.

In addition, the potential cost of health plan premiums under the President's legislation is cause for anxiety in the federal community. The federal government's share of premium costs would increase from an average of 72 percent to 80 percent under the President's plan. This sounds like a good deal for federal employees and retirees because their percentage share of premium costs would decrease. But no one knows the actual dollar amount of those premiums since the rates cannot be set until each alliance is created. And health care alliances would not be operating in all 50 states and the territories until 1998. As a result, there is no way to compare the dollar amount employees and future retirees pay for FEHBP premiums to the dollar amount they would pay under the various alliance systems. In short, the percentage of premium responsibility is not the only assurance individuals need. They also need to know a percentage of what?

With respect to these unknown premium costs, we share concerns expressed earlier by members of this committee regarding high cost areas and sparely populated areas where Amos and PPOs are neither practical nor viable.

We are troubled about the proposal to establish premium rates for individuals age 65 and older who might choose to remain in their state alliance rather than enrolling in Medicare. Rates for older participants would be established by excluding younger participants from the calculation used to set these rates. Without sharing premium costs with younger participants, older enrollees would have to pay significantly more for alliance premiums than younger enrollees.

Finally, we are disturbed by the Administration's decision to authorize, but not guarantee, supplemental and Medigap coverage to federal employees and future retirees. As members of this Committee know, authorizations aren't worth the paper they're written on without an appropriation. Without a specific mandate for supplemental and Medigap coverage, employees and future retirees will surely pay more for less health care coverage. It is as simple as that.

During last week's hearing, OPM Director James King testified that his agency needed the flexibility of making supplemental coverage optional for federal employees in order to respond to changes in the job market. But if the goal is to respond to market forces, the Administration should guarantee supplemental coverage for active employees and future retirees now. Such a guarantee would respond to today's job market and would help to make federal service a more attractive career opportunity.

At the same hearing, Health and Human Services Assistant Secretary Judy Feder's principle argument for transferring federal employees and retirees from FEHBP to the state alliance system was that it would eliminate the perception that the federal community receives better benefits and compensation than other Americans receive. If federal employees and retirees receive the same health benefits as everyone else, their benefits package would be less of a target, she said.

This is a political argument, not a policy argument. Health care reform by definition should be driven by public policy considerations, not politics. Particularly today, when federal job security and retirement benefits are being threatened, the entire federal community is understandably frightened and frustrated by administration-driven public relations arguments which compromise its health care security.

I can assure you that NARFE members are very wary about the proposed demise of the FEHBP program despite promises that they will not be among those who will pay more for less under a new national health care system. While our members subscribe to the aim of fixing what is wrong with the nation's health care system, they also maintain that what is right should be preserved.

Mr. Chairman, NARFE submits that what is right with our present system is the Federal Employee Health Benefits Program. For more than 30 years, FEHBP has done an admirable job of providing health care security to almost nine million federal employees, retirees and their families.

James Glassman of the Washington Post said in his September 17, 1993 commentary article that, "FEHBP is probably the best health insurance system in America today and the best model for the future. The reason, ironically, is that it's based on the same principles as American business: competition and consumer choice.

Indeed, the Administration turned to FEHBP as a model for many of the provisions in its own health care security plan. FEHBP is a time-tested system that minimizes costs and provides a wide choice of comprehensive plans. It seems to us to be doubly ironic that the Administration now recommends dismantling that same

program and forcing nine million enrollees into an untired system where costs and coverage are still very much at issue.

That is why NARFE urges members of this committee to ensure that federal retirees and employees continue to receive the same level of health care at the same price. Towards that end, we urge you to include language in the Administration's health care reform legislation to require the federal government to establish its own health care alliance for the purpose of retaining the FEHBP program for federal employees and retirees. Such an alliance would be similar to the "corporate health alliance" option offered to other large employers, including the U.S. Postal Service, under the President's legislation.

If we are really concerned about reforming health care for all Americans, then the argument should not be about bringing federal employees and retirees down to the level of other Americans. Instead, what we should be talking about is bringing other Americans up to the level of benefits already provided to federal employees and retirees.

Mr. Chairman, we appreciate your scheduling of this important hearing and giving us the opportunity to offer NARFE's view on the President's health care reform legislation. We also want to thank you again for urging the Administration to reexamine our concerns. We look forward to working with you and the members of this committee on provisions in the Health Security Act that affect federal retirees and employees. I would be happy to answer any questions you may have.

NATIONAL HEALTH CARE

Members of NARFE, like millions of other Americans, are increasingly concerned over the spiraling cost of health care and the effect it is having on the finances of individuals, businesses, and government. There is also shared concern for the growing number of Americans who lack the means and/or access to adequate, affordable health care coverage. Several years ago, the Association added to its legislative agenda a call for a new national health care policy.

Delegates to NARFE's 1992 National Convention adopted a resolution advocating that any national health care policy approved by Congress should include: long-term care and universal coverage for all Americans; affordable and accessible quality benefits; portability; cost containment measures on medical malpractice suites, doctor and hospital costs, laboratory and prescription drug costs; the elimination of administrative waste and complexity; and a greater emphasis on health promotion, wellness and disease prevention. At the same convention, delegates specifically turned down a resolution calling for a single-payor or Canadian style health plan for the nation. In addition, NARFE has joined with other senior organizations in requiring that long-term care must be addressed in any national health care reform plan that we support.

While NARFE is committed to the general principles of health care reform outlined above, as an organization composed primarily of retired federal civilian employees, we also have parochial concerns which must be addressed. Since the majority of our members are currently covered by one of the many health insurance plans of the Federal Employees Health Benefits Program (FEHBP), the fate of that Program and the 10 million employees, retirees and family members covered by it are of great concern to us.

Specific issues which NARFE will advocate include:

o Any proposal which will allow major corporations or employers to continue their own health care plans must also allow the government's own FEHBP to continue.

o Annuitant accessibility to the full range of health care coverage currently available to them under FEHBP must be maintained.

o The health insurance needs of the approximately 200,000 federal annuitants over age 65 **without** Medicare eligibility must be recognized and addressed.

(Position adopted by NARFE Executive Board 7/30/93)

POINTS OF CONCERN WITH BENEFITS AND COST

The Federal Employee Health Benefits Program (FEHBP) is perhaps the best health insurance system in America today because it offers a wide variety of comprehensive health plans, holds down costs and provides good service. While federal workers and retirees want to do their fair share to support health care reform, we are concerned that savings achieved from transferring FEHBP enrollees to state health alliances will lower benefits and raise out-of-pocket co-payments and premiums.

Differences in Coverage

** **Inpatient Hospitalization and Emergency Services:** Most FEHBP fee-for-service plans pay 100 percent of the cost of inpatient hospitalization and emergency services. Federal employees and retirees would pay a higher share of these costs under the Clinton plan: the federal government would only pay 80 percent of inpatient hospitalization and emergency service costs. Enrollees would pay the remaining 20 percent -- up to a catastrophic limit of $1,500 for individuals and $3,000 for families.

** **Medicare, Medigap and Out-of-Pocket Expenses**: Medicare eligible federal retirees currently use FEHBP as a "Medigap" insurance. Under this plan, 100 percent of all costs are paid because all deductibles and co-payments are waived. Federal employees who retire after January 1, 1998 would probably pay deducibles and co-payments because the administration's bill fails to mandate Medigap and supplemental coverage for future retirees.

** **Prescription Drugs**: The present Blue Cross/Blue Shield preferred pharmacy prescription drug benefit requires enrollees to pay a $50 annual deductible and a 20 percent co-payment per prescription. The Clinton plan also requires enrollees to pay the same 20 percent co-payment per prescription. However, the annual deductible would be $250 -- $200 higher than Blue Cross/Blue Shield.

** **Dental Services**: Most FEHBP fee-for-service plans provide coverage for routine dental care. The Clinton plan would not offer dental benefits for adults until the year 2000. (In fact, there is no guarantee that dental benefits will be offered even then).

** **Mental Health:** The President's plan coverage for mental health care exceeds FEHBP fee-for-service plans. For instance, the Clinton plan would provide 30 office visits per year and require a 50 percent co-payment for high cost plan participants or a $25 per visit payment for low cost plan participants..

Differences in Premium Costs

Presently, the federal government pays no more than 75 percent of the premium cost per FEHBP enrollee. The average government contribution for FEHBP fee-for-service plans is 72 percent. The President's plan would require the federal government to pay 80 percent of health alliance premiums. But no one knows the actual dollar amount of these premiums since premium rates would not be set until each state creates its own health care alliance. State alliances would not be created in all 50 states until two to three years after enactment of the Clinton plan. As a result, there is no way to compare the dollar amount federal employees and retirees pay today for FEHBP premiums to the dollar amount they would pay in the future under the administration's proposed state alliance system.

How the Proposed Clinton Health Care Plan Compares with FEHBP

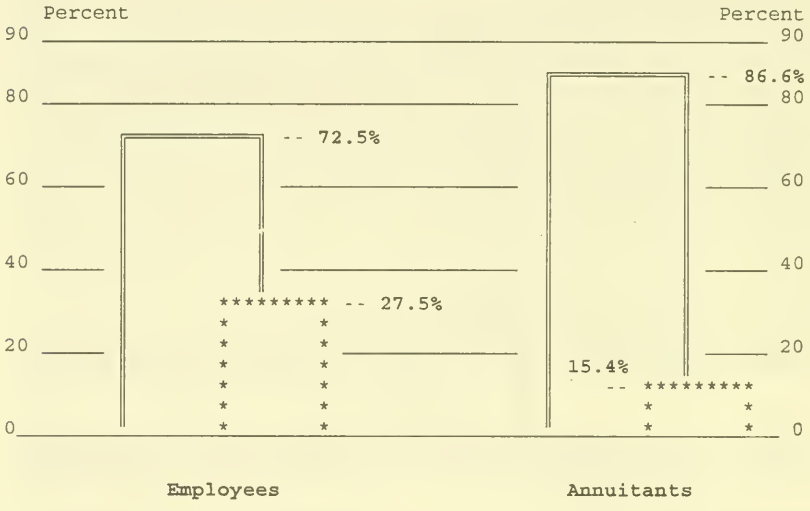
What follows is a comparison between the "High Cost Sharing" or fee for service option of President Clinton's proposed health care program and three current FEHBP fee for service plans. The administration's "Low Cost Sharing" or HMO-related option and the "Combination Cost Sharing" option will not be used in this comparison.

	Clinton Proposal	FEHBP* (1993 Benefits)		
Item	Admin.'s Standard Pkg.	Blue Cross/BS Standard	GEHA	APWU
Deductibles	$400 deductible for family coverage/$200 indiv.	$400 deductible for family coverage/$200 individual	$500 deductible for family coverage/$250 individual	$450 deductible for family coverage/$225 individual
Catastrophic Limits	$3,000 family catastrophic limit/$1,500 individual/ prescription drug catastrophic limit of $1,000	$2,500 catastrophic limit (family or individual) retail drug copayments apply to overall limit	$3,000 family catastrophic limit/$2,500 limit for individuals/drug costs do not apply to overall limit	$2,500 family catastrophic limit/$2,000 limit for individuals/drug costs apply to overall limit
Inpatient Care	80% coverage for inpatient hospitalization	100% coverage for inpatient hospitalization	100% coverage for room & board/90% for other charges	100% coverage room & board 90% for other charges
Other Services	80% coverage for surgical, outpatient & emergency services	95% coverage for surgical & outpatient services/100% for emergency services	90% coverage for surgical & outpatient services/100% for emergency services	95% coverage for surgical/ 90% for outpatient/95% for emergency services
Hospice Care	80% coverage for hospice care	100% coverage for home hospice care (limits apply	100% coverage for hospice care (limits apply)	100% coverage for hospice care (limits apply)
Home Health Care	80% coverage for home health care (reassessed for need after 60 days)	No current benefit; but home nursing care provided 2 hrs. a day for 25 visits	80% coverage for home Health care up to 120 days per year	85% coverage (75% after 1st $500) for home health care
Eye/Ear Exams	80% coverage for routine eye/ear exams and eyeglasses (children only)	1 set of eyeglasses required as a result of surgery or injury	No coverage for routine eye or ear exams or eyeglasses	No coverage for routine eye or ear exams or eyeglasses
Dental Care	80% coverage for preventive dental services for those under the age 18; additional coverage to begin in 2001	Fee schedule allowances for diagnostic & preventive services; for example they will pay up to $8 for a routine check up	Pays for 2 visits per year, up to $22 per visit	Pays for 2 visits per year up to $25 per visit
Prescription Drugs	80% coverage for prescription drugs after $250 deductible	80% coverage for retail prescription drugs after $50 deductible/ member pays only $12 for each mail order drug purchase	80% coverage for retail drugs/member pays only $20 ($5 for generic) for each mail order drug purchase	85% coverage (75% after 1st $500) for retail drugs 85% (100% generic) coverage for mail order drugs
In-patient Mental Health Services	80% coverage for inpatient mental health care limited to 30 days a yr. 60 if condition warrants (limits expire in 2001)	60% coverage for inpatient mental health services (with no deductible) up to $50,000	50% coverage for inpatient mental health services (after $500 deductible) up to $50,000	50% coverage for inpatient mental health services, after $500 deductible, up to $15,000; 100% coverage afterward up to $50,000
Out-patient Mental Health Services	50% coverage for outpatient mental health services and psycotherapy visits + $25 a visit; limited to 30 visits a year with extensions available for certain cases	60% coverage for outpatient mental health services up to 25 psychotherapy visits per year (There is no PPO option in this category, therefore a $200 deductible must be met	50% coverage for outpatient mental health services up to 30 psychotherapy visits per year after the plan's overall deductible is met	50% coverage for outpatient mental health services after $500 deductible; not to exceed $300 per person per year

All FEHBP figures reflect the utilization of preferred provider organizations (PPO) when available; non-PPO benefits are slightly less generous.

PARTICIPATION IN FEHBP

FEHBP Plans	Employees	Annuitants	Dependents	Total Coverage
Fee For Service*	1,518,437	1,433,145	3,171,661	6,123,243
HMOs	897,978	220,286	1,501,860	2,620,124
Grand Total	2,416,415	1,653,431	4,673,521	8,743,367



Participation in FEHBP fee for service plans

*** Participation in FEHBP HMO plans
***

*Government-Wide and Employee Organizations
Source: OPM, Statistical Abstracts, Federal Employee Benefit Programs, FY 1991.

The Washington Post September 17, 1993

BIG MONEY
Holding Down Medical Costs

Uncle Sam's a Smart Buyer in One Area: Health Care

By James K. Glassman
Special to The Washington Post

COMMENTARY

There are some things—believe it or not—that government does better than business. And managing a decent health care program may be one of them.

The Federal Employee Health Benefits Program, or FEHBP, is probably the best health insurance system in America today and the best model for the future. The reason, ironically, is that it's based on the same principles as American business: competition and consumer choice.

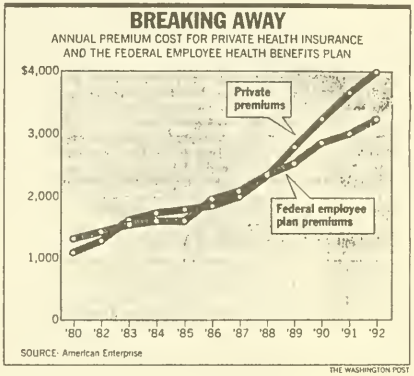
Unfortunately, the incredibly complicated plan the Clinton administration will unveil on Wednesday will bear only superficial resemblance to the FEHBP, which holds down costs and provides good service for 9 million federal employees, retirees and their families.

Unlike big corporations, the FEHBP lets federal workers pick their own health plans each year. Nationwide, there are 400 plans to choose from; in the Washington area, about three dozen. The employer—that is, the government—foots about 70 percent of the bill for the premiums, which vary widely according to what each plan offers.

For instance, the top premium for a family under Blue Cross-Blue Shield is $663 a month; under Aetna, $362. The premium for an individual under the George Washington University Health Plan is just $154 a month, with the employee paying only $38 of that.

The prices are different because the plans are different.

See BIG MONEY, G3, Col. 1



FRIDAY, SEPTEMBER 17, 1993 G3 THE WASHINGTON POST

Government Health Plan May Be a Model

BIG MONEY, From G1

Deductibles—the cost you have to pay before your plan kicks in—range from zero to $350. Some plans allow you to visit any doctor you want; some require you to see a specific group of providers. Some plans offer reimbursement for only one month of inpatient mental care; others, six months. Some pay for chiropractors; some don't. The variations are considerable, and they're widely discussed each year in Consumers' Checkbook and newspapers, and at health fairs. One of the few requirements is that a plan can't turn down an employee because of a "preexisting" medical condition.

The key is that the ultimate choice is the employee's, not the employer's. Employees have their own money at stake, they know their own needs, and, at least in theory, they choose wisely.

Market pressures help make the system work: Insurance companies and health maintenance organizations (HMOs, or groups of doctors) slug it out for business, with an enormous incentive to keep costs low. Federal workers can choose a new plan at year-end, and plans that can't compete on price, benefits and quality drop by the wayside.

How well does the system hold down costs? Walton Francis, a federal bureaucrat who has made the FEHBP his passionate avocation, has compiled figures that show that since 1982, the federal plan's premiums have risen an average of 8.9 percent annually while private premiums were rising 12.6 percent a year.

The Clinton plan seems, on the surface, to have many of the same features as the FEHBP. But it will almost certainly work very differently because the government reserves an important power—it can impose a cap on premiums.

Since the government also will establish the minimum features of the plans that Americans can select, the likely result will be that these government minimums will end up being fixed prices for fixed plans—in effect, price controls.

Lowering prices by decree is a dubious proposition. Even by dictating the precise cost of each medical procedure, the federal government has had little success keeping down Medicare expenses. Over the past 20 years, the number of persons served by Medicare (for the elderly and disabled) has risen 70 percent while expenses are up more than 1,400 percent.

One difficulty with any top-down system run by the government is that it will be subject to political pressure. Francis cites as an example the Medicare deductible, which is a mere $100.

Why hasn't it been raised to a reasonable level, just to keep pace with inflation and save the taxpayers billions? Because, says Francis, to raise it "is a political act, an act which is certain to cost 35 million Americans directly, dollar for dollar, money they don't want to lose. The political system is not about to inflict that harm on them if it can possibly avoid it."

Medicare also sets different prices for procedures performed in hospitals in different regions. Those regions are determined on a subjective basis, and hospitals lobby hard to get moved into a region where the government will pay them a higher rate. Again, it's a political decision, not an economic one.

There's already brutal political competition among providers to get their specialities included in the Clinton administration's basic package. What about eyeglasses? Orthodontia? Visits to psychiatric social workers and osteopaths? Even if Hillary Rodham Clinton's task force can make "objective" decisions on these touchy questions, members of Congress will be pushed hard by lobbyists and constituents.

The power of a system of free-market prices lies precisely in the fact that it is ultimately independent of the whims of government. If the government ordered that hamburger be sold at no more than 10 cents a pound, the supply of hamburger would shrink, lines would form for the tiny amount that would be available and the quality of the meat would decline sharply.

Another alternative, of course, is that, goaded by government decree, the beef industry might learn to make hamburger cheaper. Maybe. But the incentive to make hamburger as inexpensive as possible already exists—thanks to competition among hamburger suppliers, not to mention chicken suppliers.

In the end, price controls tend to result in scarcity, and controls on health prices probably will be no different.

Still, anyone who tries to make the case for competition has to explain current health care costs. We're supposed to have competition today, yet businesses spend 12 times as much on health care as they did 20 years ago, and individuals spend seven times as much. Total costs approach $1 trillion, or about what we spend on food. That's one-seventh of our gross domestic product.

Why are costs so high? Theories abound. Health providers may be venal (after all, the average surgeon made $221,000 in 1989). Hospitals may be poorly managed. Medical malpractice may take a high toll (insurance premiums have tripled in seven years). Businesses may be lax in choosing the best policies for their workers. Insurance companies may collude on prices.

But there's another reason for the high cost of health care: hot demand. Health care is something Americans want fiercely, and for obvious reasons. In his fascinating study of American consumers in the 20th Century, "Pursuing Happiness," Wesleyan University economist Stanley Lebergntt writes: "The greatest spending increases from 1900 to 1929 did not go for necessities, or luxuries, or nonessentials. They were spent for items, in every category, that promised to extend lifetime hours of worthwhile experience. To lengthen life, the most obvious tactic would appear to be to spend on medical care."

This spending intensified after 1946 with the introduction of sulfanilamide, penicillin and widespread X-rays. And it has soared with heart bypasses, quick hip-replacement procedures, miraculous eye surgery.

The plain truth is that health care is expensive because we love the stuff—and the government helps feed the demand through tax breaks and subsidies. The Clinton plan offers even more subsidies—insurance for the 15 percent of Americans who don't have any.

Can reordering the system have an effect on those prices? Perhaps, but I'm not too sanguine on the prospect. Still, the best chance for success may be to allow all Americans to join the FEHBP plans that already exist throughout the country and to start similar ones elsewhere.

Couple the FEHBP system with a federal requirement that private employers, like the government, have to pay 70 percent of the premium bill for their employees. That might do the trick.

Mr. MCCLOSKEY. Our final panelist is Gene Voegtlin of the Federal Managers Association. Welcome.

Mr. VOEGTLIN. Thank you, Mr. Chairman. I want to thank you for the opportunity to appear before you this morning to offer the testimony of the Federal Managers Association on the Health Security Act of 1993.

As you know, FMA is the Nation's largest Federal professional management association, representing the interests of over 200,000 Federal managers and supervisors throughout the Federal Government.

Before I begin, I would like to express FMA's thanks to this committee for your successful efforts in altering the administration's original plans to phase out FEHBP over the next few years.

Like you, FMA believed that such a phase-out of FEHBP would have been unnecessarily disruptive and costly to Federal employees. FMA applauds the commitment and the effort that the Clinton administration has put into solving one of the Nation's foremost problems.

FMA supports the concept of a health care reform package that would provide all Americans with access to adequate and affordable health care.

However, FMA is extremely concerned over the impact of the Health Security Act on Federal employees and retirees.

FMA is concerned that the decision to terminate FEHBP is based upon political considerations rather than on a careful review of what many consider to be a model health care program.

The administration seems to believe that placing Federal employees into the new health care system will help to demonstrate the attractiveness of the new system to the American public.

What the administration seems to ignore is that, by abolishing the FEHBP, for these reasons, they are terminating a very successful, cost-effective program.

FMA believes that, at a minimum, the reform proposal should maintain a separate system for Federal employees that provides them with at least the level of benefits that they currently receive.

During the past 18 years, enrollees in FEHBP have seen their annual premium cost rise at a rate that is on average 2 to 3 percent lower than their private sector counterparts. By maintaining Federal employees in a single, separate system, the Government would realize that twin benefits of a more cost-efficient and cost-effective health system.

In addition, maintaining Federal employees in a single system would prevent the possibility of disparities in coverage developing between Federal employees who are located in different regions of the country.

For example, FMA is concerned that the breaking up of the Federal work force into different regional alliances could lead to significant differences in the premium rates that are paid by employees.

If the region is split into Federal alliances, employees who live in rural, less populated States will be forced to participate in alliances that have less buying power than those alliances located in the more populous States.

To compensate for the lack of buying power, these smaller alliances will be likely to charge higher premium costs.

FMA believes that by maintaining a separate system for Federal employees, we will be able to ensure that all Federal employees pay the same premium rates.

Unfortunately, the administration appears determined to terminate FEHB and transfer all employees into a comprehensive alliance system under the Health Security Act. If this should occur, despite our strong feelings about its wisdom, FMA would like to voice a few specific concerns with the Health Security Act.

First, FMA is very concerned over the lack of information in the cost of increase in the Federal employees premium cost.

As addressed in last week's hearing and mentioned by the panelists before me, although the Government share of the premium cost will be increased from 72 to 80 percent, we still have no definite information as to what this base cost shall be.

Second, FMA is also concerned over the 80-percent limit that is going to be placed on hospitalization costs for individuals who enroll in a fee-for-service plan.

As you know, 65 percent of Federal employees are currently enrolled in some form of a fee-for-service plan which provides 100-percent coverage for hospitalization costs. FMA believes that this 20-percent copayment under the Health Security Act represents a serious increase to the costs to Federal employees.

I would also like, third, to reiterate the comments of our—my fellow panelists on the concerns over the supplemental and Medigap coverage for Federal retirees. As they have stated, the supplemental coverage has been guaranteed for current Federal retirees, and FMA hopes that this could also be guaranteed for future Federal retirees.

Finally, FMA believes that we should ensure Federal employees are not transferred into a regional alliance until the level of coverage provided by the alliances matches the current Federal standard.

In conclusion, FMA is opposed to sacrificing the successful FEHBP for reasons that are unrelated to its performance. If the termination of FEHB cannot be avoided, FMA urges that Federal employees not be asked to pay more and receive less.

FMA believes that if—as Director King stated last week—FEHB is one of the models for health care reform, then the goal should be to provide all Americans with the benefits currently received by employees and not to reduce the benefits received by Federal employees currently.

FMA looks forward to working with this committee, Congress, and the administration in the continuing effort to reform the national health care system.

And I, once again, thank you for the opportunity to appear before you today and for all of your efforts on behalf of Federal employees.

[The prepared statement of Mr. Voegtlin follows:]

PREPARED STATEMENT OF GENE VOEGTLIN, LEGISLATIVE REPRESENTATIVE, FEDERAL MANAGERS ASSOCIATION

Chairman Clay and Members of the Committee: Thank you for the opportunity to appear before you this morning to offer testimony on the Health Security Act of 1993. As you know, the Federal Managers Association is the nation's largest Federal

professional management association, representing the interests of over 200,000 Federal managers and supervisors throughout the Federal Government. We have a strong interest in this legislation because of its effects on Federal employees.

First, FMA would like to express its thanks to you, Mr. Chairman, and your colleagues for your successful efforts in altering the Administration's original plan to phase out FEHBP over the next few years. Like you, FMA believed that such a phase-out of FEHBP would have been unnecessarily disruptive and costly to Federal employees.

FMA applauds the commitment and the effort that the Administration has put into solving one of the nation's foremost problems. FMA supports the concept of a health-care reform package that would provide all Americans with access to adequate and affordable care. However, FMA is extremely concerned over the impact of the Health Security Act on Federal employees and retirees.

FMA is concerned that the decision to terminate FEHBP is based upon political considerations rather than on a careful review of what many consider to be a "model" health-care program. The Administration seems to believe that placing Federal employees into the new health-care system will help demonstrate the attractiveness of the system to the American public. What the Administration ignores is that by abolishing FEHBP for these reasons, they are terminating a very successful, cost-effective program.

FMA believes that, at a minimum, the reform proposal should maintain a separate system for Federal employees that provides them with at least the level of benefits currently received under FEHBP. During The past 18 years, enrollees in FEHBP have seen their annual premium costs rise at a rate that is, on average, 2 to 3 percent lower than their private-sector counterparts. By maintaining Federal employees in a single, separate system the government would realize the twin benefits of a more cost-efficient and cost-effective health system.

In addition, maintaining Federal employees in a single system would prevent the possibility of disparities in coverage developing between Federal employees located in different regions of the country. For example, FMA is concerned that breaking up the Federal workforce into the different regional alliances could lead to significant differences in premium rates paid by Federal employees. If the workforce is split, Federal employees who live in rural, less populated states will be forced to participate in alliances that have less buying power than those alliances located in more populous states. To compensate for heir lack of buying power, these smaller alliances will be forced to charge higher premium costs. Maintaining a separate system for Federal employees will ensure that all Federal employees pay the same premium rates.

The Administration appears determined to terminate FEHBP and transfer all Federal employees into a comprehensive system under the Health Security Act. If that does occur, despite our strong feelings about its wisdom, I would like to address several specific concerns with the Health Security Act.

First, FMA is very concerned over the lack of information on the possible increase in Federal employee premium cost. As addressed at last week's hearing, although the government's share of the premium cost will increase from 72 to 80 percent, we still have no idea as to what the base cost will be.

Second, FMA is very concerned over the 80-percent limit placed on hospitalization costs for individuals enrolled in a fee-for-service plan. As you know, 65 percent of Federal employees are currently enrolled in some form of a fee-for-service plan. This 20 percent copayment represents a serious increase in the costs to employees.

Third, FMA is concerned over the ability of future retirees to participate in "supplemental plans" that would expand their health-care coverage. Thanks to the efforts of this Committee and others, the ability of current retirees to enroll in "supplemental plans" has been guaranteed. FMA hopes that this guarantee can be extended to all future Federal retirees as well.

Fourth, we should ensure that Federal employees are not transferred into regional alliances until their level of coverage matched the current Federal standard.

In conclusion, FMA is opposed to sacrificing he very successful FEHBP for reasons that are unrelated to its performance. If the termination of FEHBP cannot be avoided, FMA urges that Federal employees not be asked to pay more and receive less. FMA believes that if, as Director King has stated, FEHBP is the model for the health-care reform plan, than the goal of the reform plan should be to provide all Americans with the benefits currently received by Federal employees, not reduce Federal employee benefits.

FMA looks forward to working with this Committee, Congress and the Administration in the effort to reform the National health-care system.

Once again, Mr. Chairman thank you for the opportunity to appear before you today on this important issue and for your efforts on behalf of Federal employees.

Mr. McCLOSKEY. Thank you very much, Mr. Voegtlin. With perfect timing. The Chairman has returned.

I might note, though, that Mr. Carter had lamented your absence, particularly with a reference to an inspirational speech you gave several years ago. I am choking up.

Mr. CLAY. [presiding]. You should have been there to hear it. It was inspirational.

Who is the next witness?

Mr. McCLOSKEY. The panel has completed.

I might note that Mr. Ackerman has joined us.

I think whatever questions or statements you might have, Mr. Chairman, you can start off again.

Mr. CLAY. Well, I am going to turn it over to you for questions right now.

Mr. McCLOSKEY. Thank you very much. Just maybe a general observation or two. I don't know if it really goes to the precise—I am going to forego.

Mr. ACKERMAN. If I might, Mr. Chairman.

Mr. CLAY. Mr. Ackerman.

Mr. ACKERMAN. Thank you, Mr. Chairman. I think it was 4 or 5 years ago during a hearing that I had the pleasure of chairing, at least 50 percent of this panel participated in a panel during which I asked a question when we were discussing the reaffirmation of FEHB, that if the benefit package that we came up with exceeded the package of benefits that existed, would you be supportive of that reform; and the answer was, from everybody, in the affirmative.

I would like to just recast that question at this time with respect to the President's proposal. When completed, if that package offers a benefit package which is acknowledged to be richer than the benefit package in FEHB, would you be supportive of the President's package?

Mr. STURDIVANT. Yes. Yes, we would support that.

Mr. TOBIAS. I think we would support it. I would be interested in knowing how the costs would be allocated.

We are certainly interested in maintaining benefits, but we are also very concerned about how the costs are calculated. And at this time, we don't know how costs are calculated.

Mr. ACKERMAN. How they are calculated or allocated?

Mr. TOBIAS. Both.

They keep changing because we don't have fixed—we don't have any fixed costs regionally. And the benefits keep fluctuating.

So for both of those—on both of those bases, you can't figure out what the contribution will actually be. So I would say a qualified, yes, based on how the costs ultimately shake out.

Mr. ACKERMAN. Thank you.

Mr. Carter.

Mr. CARTER. As retirees, again, we would like to be, as I said, not divided and conquered.

Part of our base and part of our cost containment is that we remain with the new employees and the old employees stick together. That would have to be something given consideration. And that is one of the reasons we feel that we should be treated as General Motors would or the postal workers, as proposed.

We need to keep that combined group together because that really affects the actuary studies. It affects the costs for us as retirees. And we, as we say, don't want to be divided and conquered on this issue.

But basically, if we could just maintain the same level of status, we aren't looking for anything much richer. We are pretty happy with what we got. It could be better, but we are happy with what we have.

Mr. VOEGTLIN. I would have to go with Mr. Tobias with a qualified, yes, depending on the cost shake out.

Mr. ACKERMAN. But if the cost share was relatively the same and the package was at least as good or richer, you would have no problem?

Mr. VOEGTLIN. I don't believe so, no.

Mr. TOBIAS. No.

Mr. ACKERMAN. I understand that Mr. Hoyer made reference—and I am sorry, also, that I was late—to a question that I had asked the panel at the last hearing. And that was: What would happen to the employees? What would happen to the savings? Would they be passed on to the employees as part of their same compensation package as the Treasury Secretary is selling this package to the American people, the American work force? He is telling them that all of these savings from their health care benefits will be passed on to them from their employers as part of their cash compensation package.

Have you given much thought to a position on that as well? Should the company store make—keep all the savings, or should they be sharing that with you all?

Mr. TOBIAS. We are very interested, Congressman Ackerman, in gain sharing. We want some of those gains to come back this way instead of constantly disappearing into the dark hole of the Federal coffers.

The thrust of NTEU's position is that we should be treated no differently than the private sector. Really, what we are talking about in the first instance is the employer/employee relationship; and, second, we are talking about health care as a national issue.

I think it is often difficult to keep those two interests and issues separate, because obviously, this panel has an obligation to the Nation as a whole; but as part of this group, an obligation to looking at the employer/employee relationship. And, in that context, the idea that cost savings are returned to those employees in the public sector in the same way they will be in the private sector is something that we would certainly support.

Mr. CLAY. Mr. Ackerman, could we take a break and come back in 15 minutes?

Mr. ACKERMAN. Sure. That is my last question anyway.

Mr. STURDIVANT. Mr. Chairman, given—just to piggyback on that a little bit, given the amount of sacrifices that the people that we represent have been asked to make in the name of deficit reduction and continue to be asked, even right now, this week, then we would be—we would expect that some of those savings would come back to the employees. And, in fact, we would insist that some of those savings come back for the employees to make up for some of the losses that they have experienced over the years.

Mr. ACKERMAN. What you are saying, basically, is that the American work force is going to realize the savings on an individual and personal worker basis, that Federal employees should be treated no different, and if you want to contribute that back to the deficit reduction, you can make out your own check. Is that it?

Mr. STURDIVANT. Yes.

Mr. ACKERMAN. Thank you very much.

Mr. CLAY. The committee will recess for 15 minutes.

[Recess.]

Mr. CLAY. The committee will come to order.

At this point we will recognize Mr. Moran.

STATEMENT OF HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. MORAN. Thank you very much, Mr. Chairman.

I know that our colleagues are on their way back from the vote. This is an important hearing that you are having today, as you know, more important for some of us, with as many Federal employees as we have.

We found that we have over 70,000 active Federal employees in my congressional district. There are another 20,000 Federal retirees. And if you count their family members, who are covered under the Federal Employees Health Benefits Program, we are talking about almost 200,000 people in one congressional district affected by what we do with the Federal Employees Health Benefits Plan. So you can imagine, I have a keen interest in this issue.

We do applaud the President and Mrs. Clinton for bringing a very complex and highly emotional issue to the forefront of public debate. And they have done it in a comprehensive, responsible manner.

But I would be remiss if I didn't urge this committee particularly, and the other committees that will take this legislation to analyze it very carefully. Like all of our colleagues, I have held a number of health care town meetings.

At those meetings, it becomes clear that most of the people are unaware of the reasons for spiraling health costs, and they are misinformed about the role that the uninsured play in causing those health costs to increase so dramatically.

They are concerned particularly about the disruption that the Federal Employees Health Benefits Plan might have in their relationship with their current health care providers. They are concerned about the intrusion of government into their medical decisions. And these are even Federal employees, which I found a little ironic, being themselves concerned about the intrusion of government into their lives. But, nevertheless, that is one of their concerns.

And they are concerned about the potential for their premium costs to increase as the uninsured come into the risk pools, which is a very valid concern.

My Federal employee constituents are afraid that they may very well become a scapegoat within this health care debate. The Federal Government was not treated as other large employers, large employers who currently offer a very good health care plan that their employees are satisfied with. Every other large employer gets

exempted under the administration's plan, but not Federal employees.

I think the reason for this different treatment is that some people felt that it is not good politics to exempt Federal employees. It is good politics to bash Federal bureaucrats, to show how tough you are getting on Federal employees. That is not the philosophy of this committee fortunately and, I trust, not of the Congress, nor of the White House.

But I do believe that they are right, too, when they feel that this may be part of the motivation for their receiving different treatment than other employees employed by large organizations who are exempt.

Specifically, the problem with the administration's health care plan is that there is limited coverage for hospitalization under fee-for-service plans.

Currently, if they choose a fee-for-service plan and are willing to pay the additional premium, they get 100-percent hospitalization coverage.

Under the administration's plan, they don't. They get 80 percent.

Mr. CLAY. Who is this "they?" You are talking about "we?"

Mr. MORAN. We. We. We get. I thank you very much for correcting the record, Mr. Chairman. This is "we."

We have identified the subjects that have the problem, and it is we.

We are also concerned that the Federal Employees Health Benefits Plan would get disassembled. We would have to go back to our region of residence and then enter into a plan within that place where we live.

I am not going to get into the situation with Members of Congress, but clearly there is a great deal of disruption from people who are currently getting their health insurance plan at work in the most efficient way possible.

Under this plan, it gets totally disassembled, dismembered, and we have to go back to the place where we live and go through a whole different system.

They are concerned about OPM's administration of the Medigap plan to Medicare eligible Federal annuitants. The President's plan, in many ways, is modeled after the Federal Employees Health Benefits Plan. We have regional health alliances acting as consumer purchasing cooperatives, that is not dissimilar from the role that OPM currently plays. They are responsible for ensuring that we have qualified plans that offer federally mandated benefits packages. That kind of comparison shopping between plans for price and quality makes a lot of sense.

It doesn't happen now. I don't know why OPM can't make it happen. It can't compare price and quality. There is no reason why OPM can't perform that function and make the Federal Employees Health Benefits Plan a better plan than it is today, modeled after what has been recommended.

Mr. CLAY. Can I ask Mr. Moran to wrap up his statement.

Mr. MORAN. Oh, sure. I have other points to make.

It is clearly beneficial for Federal employees to be paying only 20 percent compared to the roughly 28 percent that many now pay.

But when you compare it all, I think the point remains that Federal employees are well covered now. They like the plan they are in. It makes sense. We could improve it. But what has been offered may very well make matters worse. And it seems to me, when we have something that is working, if it is not broken, why try to fix it?

So I appreciate the time that you have extended me, Mr. Chairman. I particularly appreciate your interest and involvement in this issue, as well as that of the other panel members.

Mr. CLAY. Thank you.

[The prepared statement of Hon. James P. Moran follows:]

PREPARED STATEMENT OF HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman: I want to thank you for having this hearing today. The Health Care issue may have been overshadowed recently by the NAFTA debate, but it remains the most important we will discuss this Congress.

Like Steny Hoyer, I am here as a member of Congress who represents federal employees. In fact, my district contains 69,890 active federal employees and 20,040 federal retirees. Almost 90,000 of my constituents and their families are either FEHBP participants or FEHBP eligible.

Like you, Mr. Chairman, and the other members of the Committee, I share the concerns of my constituents and I have others concerns about the Health Security Act. In particular, I am interested in the: limited coverage for hospitalization under fee-for-service plans; transition of FEHBP enrolles into Regional Health Alliances; and the Office of Personnel Management (OPM) administered Medigap plan to Medicare eligible Federal annuitants.

On a positive note, the President's Health Security plan is modeled after the Federal Employees Health Benefits Program and preserves the best parts of the program.

I applaud the President and Mrs. Clinton for bringing the complex and highly emotional issue of health reform into the forefront of public debate in such a comprehensive manner. I would be remiss, however, if I did not carefully examine the health care package and carefully analyze the impact it will have on the bulk of my constituents.

Like Steny Hoyer and most other members of Congress, I have held a series of Health Care town meeting forums to inform my constituents about the Clinton Health Care Package and to listen to their concerns.

At those meetings, I found that most people in my District are unaware of the reasons for spiraling health costs and are misinformed about the uninsured.

Most importantly, my constituents are concerned about: a potential disruption in their relationship with their providers, the intrusion of government into their medical decisions, and the potential for their premium costs to increase as the uninsured come into the risk pools.

My federally employed constituents are afraid that they will become the guinea pigs for this new health care package and that the Federal Employee Health Benefits Program, with which they are very satisfied, will be dismantled overnight.

Regional Health Alliances act as consumer purchasing cooperatives, similar to the role of the Office of Personnel Management, under FEHBP.

Unlike OPM, the Health Alliances are responsible for ensuring that all qualified health plans offer the federally mandated benefits package to consumers. This would facilitate comparison shopping between plans based on price and quality, which does not now happen.

The President's plan requires that all health plans offer the federally mandated comprehensive benefits package to consumers.

I understand that this package is very generous and comparable to the FEHBP Blue Cross/Blue Shield standard option plan. There are added benefits which include: mental health services, prescription drug benefits, and preventive health services.

In addition, the premium costs for federal employees should be reduced by the Health Security Act. As you know, federal employees pay 72–75 percent of their health care premium under FEHBP. Under the President's plan, their share would be reduced to 20 percent of the weighted average premium of the alliance.

The package, however, does not fully meet the coverage of the FEHBP. The fee-for-service option in the President's plan limits hospitalization coverage to 80 percent, with a co-payment of 20 percent.

As you know, approximately 65 percent of the 9 million federal workers, retirees and dependents who are enrolled in FEHBP are participating in a fee-for-service plan. Requiring a 20 percent coinsurance for inpatient hospitalization represents a reduction in benefits for FEHBP enrolles currently in fee-for-service plans.

This reduction could be much more significant than the savings federal employees will realize from the government paying a higher premium percentage.

Another concern of mine relates to the OPM administered Medigap plan that has been proposed to replace FEHBP as the secondary payer for Medicare Part A eligible FEHBP enrolles.

Currently, all FEHBP plans waive all deductible for Medicare eligible enrolles.

It is not clear that the OPM administered supplemental plan is going to have the same level of benefits as federal workers or future federal retirees now have.

We must ensure that the OPM administered Medigap plan should provide the same level of coverage as is currently provided to Medicare eligible FEHBP enrolles.

These are only a few of the concerns that have been addressed to me and that I have with the Health Security Act. Like you, and most other Members of Congress, I am very pleased that the President has opened this debate.

I hope we can all work together, with the White House, to ensure that the package that is finally signed into law is the best for the American people and our federal employees.

Thank you very much for inviting me to appear before the Committee.

Mr. CLAY. Mr. McCloskey.

Mr. MCCLOSKEY. Mr. Chairman, I just want to say, in many ways, I am at a loss for words today, checking out my own Federal health benefits. I want to thank every one.

Thank you.

Mr. CLAY. Mr. Bishop.

Mr. BISHOP. Thank you, Mr. Chairman. Let me just ask one brief question.

I am very interested in the comments that you made regarding savings to employees, that you would much rather that they go back and let the employees reap the benefit of them. Let me just ask you about the tax consequences of that.

What would the tax consequences be if the savings are taken away from benefits within—are given back to the employees in the form of salary increases?

Would that not subject them to some additional taxation, income-tax-wise?

Mr. TOBIAS. It would.

Mr. BISHOP. It would actually reach in their pockets deeper than it would otherwise? I am just asking the question. I don't know.

Mr. TOBIAS. It would. And I don't think that we would be asking for some special dispensation. We were asking to be treated as those in the private sector. And if there are savings in health care in the private sector, the President has said that it will result in increased pay, that instead of the benefits package now being weighted in favor of health care and not in favor of pay, that the weights would change and, in the private sector, the tax consequences would be that people would pay for tax on the salaries received.

And NTEU would support the same application for those in the Federal sector.

Mr. STURDIVANT. At some point in time, if you make more money, you are going to have to pay more taxes, unless you make so much money that you can hire somebody to tell you how you

don't have to pay those taxes. We don't represent those people. We represent people—we represent Federal employees who, over the past 12 years, have given back approximately $163 billion in pay freezes, cuts in benefits, toward deficit reduction. That does not include what our Federal employees gave in this last budget that was recently adopted.

So what we are saying is, we have already given enough toward the genie or the altar of deficit reduction. If there are savings in the health benefits plan that would come back as a result of this process, then it would be our position that some of these savings come back to Federal workers in the form of increased pay in order to make up for some of the cuts that we have taken over the prior years.

Mr. BISHOP. I don't want you to misunderstand what I am suggesting, because I certainly think that Federal employees and retirees have contributed a great deal to the deficit in the form of lost benefits and lost wages and COLA's and the like.

But, again, I was a little bit concerned to make sure that if you apply those benefits back in in the form of salaries, are you not really taking away what is now a nontaxable item and making it a taxable item?

Mr. CARTER. Congressman Bishop, I would like to add that Federal retirees also made a contribution of $31 million to the deficit. We have a lot of survivors and orphans out there involved. And some of them are struggling, struggling just to pay the health care costs because the annuities that they are receiving are insufficient. They have to supplement their annuity.

And then some lawmakers have proposed is further cuts in our COLAs. That is another affront to us as retirees. And I think it is a low blow when we pick on our widows and widowers and we pick on our orphans.

Mr. VOEGTLIN. I think that if we are going to the truth, it comes down to losing a nontaxable benefit or gaining a taxable benefit, I think they will take the taxable benefit.

Mr. BISHOP. Very good.

Thank you.

Mr. CLAY. Mr. Wynn?

Mr. WYNN. Thank you, Mr. Chairman.

You may have covered this; and I apologize for coming in late, but is there an offset as between the reduction in benefits and the additional cash savings that are alleged to accrue?

Mr. STURDIVANT. The savings as far as if the plan is less costly?

Mr. WYNN. Yes.

Mr. STURDIVANT. I don't see that there would be an offset. Basically, what we are saying is—and this was a follow-up on, I guess, a question where Treasury Secretary Bentsen was promising private corporations that the reduced costs that they would have for health benefits premiums could be applied back as pay increases for private sector employers.

What we are saying is we think that Federal workers should be treated the same. And if there are increased savings to the government because of less costs, then part of those savings should be applied back for Federal workers.

Mr. WYNN. If that were to happen, would you be satisfied that that was a reasonable offset, if that were to happen?

Mr. STURDIVANT. An offset for what?

Mr. WYNN. An offset for the reduced benefits that the Federal employee would have to go and purchase.

Mr. STURDIVANT. Oh, no. In our testimony, we have said that the existing Clinton plan, the benefit structure does not meet our standards and it needs to come up higher. So this would be in addition to improving the benefit structure in order to make sure that Federal employees not only just remain the same but do better.

Mr. WYNN. So your ideal model would envision the Federal Employee Health Benefit Plan as an alliance onto itself?

Mr. STURDIVANT. At AFGE, we don't necessarily support the Federal employees—we are not wedded to the Federal Employees Health Benefits Plan being an alliance to itself.

In fact, in AFGE, we don't support other large corporations being alliances to themselves either.

What we have tried to do is to look at what type of health insurance—what would be the level of benefits, what would be the level of premiums—and to make sure that Federal employees, regardless of what type of program they were in, would not be worse off, would be better off, and would have good health care.

Mr. WYNN. Then I hear you saying that you object to the alliance as a model or a vehicle.

Mr. STURDIVANT. Well, what we are saying is that we are not necessarily wedded to FEHB remaining intact, as long as wherever Federal employees go in the alliances—we don't object to the alliances themselves as a model.

What we are saying is that the alliances should not be so constructed that Federal employees would have less benefits for more cost.

Mr. WYNN. OK. And you mentioned hospitalization.

Are there others that you are particularly concerned with?

Mr. STURDIVANT. Hospitalization. And also I think several other levels of benefits that are in my testimony, that don't come to mind right here.

Mr. WYNN. Was dental a concern?

Mr. STURDIVANT. Yes.

Mr. TOBIAS. Adult dental care, emergency services, those are all provisions that are available to current Federal employees that are not available under the proposed Clinton plan. And we are particularly concerned that that plan, as proposed today, I suspect, will erode as we progress toward enactment.

It was just announced today that certain substance abuse mental health benefits would be eliminated from the basic plan that would be available under the alliances.

So we are concerned that whatever Congress enacts, if it enacts health care reform and it has a level of benefits, that Federal employees be able to maintain the level of benefits that they have today, that they be no worse off than they are today. And that is certainly the thrust of where NTEU is.

Mr. WYNN. Just one other question, Mr. Chairman.

Currently, temporary Federal employees, some of whom have worked for 8 to 10 years, are not offered health insurance. What

would happen to these employees as you envision it? What do you envision will happen to these employees?

Mr. STURDIVANT. Well, actually, in AFGE, our position is—and if you look at the President's principles for health care, the President's principles for health security that he has laid out, our position is that if the President really wants to move in that direction, he should apply those principles to temporary employees now.

Mr. WYNN. OK. Thank you.

I don't have any further questions, Mr. Chairman.

Mr. CLAY. Thank you.

Let me ask you this about the distinction that the President's plan is making in terms of certain categories of employees.

Would one of you, or each of you, care to comment on the administration's decision to treat employees and future retirees differently than current retirees?

Mr. TOBIAS. Do you want to start with that one, Charles?

Mr. CARTER. Well, being the elder here with the gray hair, we think it is unfair to change the ground rules.

One of the attractions of coming into Federal Government is the fact that it does provide some good benefits. And we are not going to say, on our end, that we are willing to sacrifice the future retirees for what we want for our future. We feel you should treat us all right and treat us all fair.

Just looking at it from our standpoint. You are asking us right now to take 50 unknowns in 50 States. We also represent three territories and some overseas people that are involved and are going to be affected by this legislation. We have people in rural areas, Congressman, that don't have an HMO, don't have preferred provider plans that they can get into. They don't know what is going to happen to them.

The unknowns here for us are real. And why would we ask for more unknowns for those who are going to be future employees and retirees?

Mr. TOBIAS. I think that it is basically unfair to guarantee benefits to existing retirees and not guarantee those benefits to new retirees or active employees.

I think creating the disparity in benefits defeats the purpose of providing health care which I think is to serve the national interest but, secondly, to serve the interest of the Federal Government as an employer.

A two-tiered system for benefits would not serve the interest of the Federal Government as an employer. And I think that that interest, that issue also has to be kept paramount, particularly in this committee's mind, because, as I see it, this committee has the responsibility—and you certainly have taken this on—to keep a focus on the fact that Federal personnel policies are not national policies but define the employer/employee relationship; and a two-tiered system would be really antithetical to that interest.

Mr. STURDIVANT. We don't support two-tier pay systems or two-tier benefit systems. And basically what this appears to be is just a move to delay dealing with tough political questions now in the hopes that somebody in the future might deal with them.

If we are going to go through all this turmoil to deal with health care and the question of health care for this country, let's deal with it now.

Mr. VOEGTLIN. I would have to agree. I think the idea of segregating between current and future retirees is very unfair. And I know that FMA is opposed to such a segregation.

Mr. CARTER. Anticipating one of your questions, Congressman, we also take a real exception to means testing. That is another one that defeats whatever you are trying to accomplish. You are going to be penalized for accomplishment. And I don't know how you add means testing to solve this problem. We want a fair, equitable plan for all Americans.

Mr. CLAY. Thank you.

Mr. Sturdivant, in your written statement, you propose using the BlueCross BlueShield standard benefit plan as a reference point in deciding what benefits should be included in supplemental benefits; and you also propose that the Government pay 90 percent of the costs of the standard benefit package and supplemental benefits.

Would you explain why you selected BlueCross BlueShield? And would you make further comments on your proposed 90 percent contribution?

Mr. STURDIVANT. On the Blue Cross/Blue Shield, basically, we looked at that one because, with all of the plans you have, we tried to find one that had a large number of Federal employees in it, and Blue Cross jumped out.

We realize that there are other plans that either could be comparable or might even have better benefits, but it seemed that that is one of the largest, that is one that is selected by a large number of Federal workers. And we felt that it would give us a frame of reference.

As far as the 90 percent, as far as the Government paying 90 percent of the cost, basically we have said all along that the Government—that we would not support a plan that had Federal employees paying more money for less health care.

But as we begin taking a look at this and listening to some of the comments that you made in prior hearings, certainly we think that the Government should be a trend-setter. And the Government—there was one time in this country that the Government set the standard rather than lowered the standards. And we felt that this would begin to move us in a direction of having a standard that you could bring the rest of the country up to as far as having comprehensive health care and what is paid.

Mr. CLAY. Anybody else want to comment?

Mr. TOBIAS. We certainly think that the Blue Cross/Blue Shield approach is a fine construct for analyzing what the basic plan should be.

With respect to the Federal Government paying 90 percent, I think that is also a very interesting approach. I continue to be concerned about the issue of 90 percent of what? We don't know what these alliances are going to cost in particular geographic areas. So I am interested in finding out what those costs are so that we are providing health care, the same amount of benefits at the same amount of cost as we are doing today.

Mr. CARTER. As President Sturdivant said, Congressman Clay, Blue Cross/Blue Shield has basically set the trend ever since FEHBP came into existence. And I joined back in the 1960's.

However, there are some other great companies out there, such as the Government Employees Hospital Association that is in Kansas City. They do a great job. They are the third largest group insuring Federal employees. And they seem to operate under the guidelines of OPM.

I was amazed that they didn't have executives over there getting $250,000 a year with a bunch of perks. I was amazed that the vice president was arriving in a secondhand car. So I was very pleased.

And the reason for that is because of cost containments in the plan that didn't allow these executives to take big perks. I am proud of a company like that. And I think there is more out there like them. That is the kind of plan what we should be looking for. We should not allow the private sector to profiteer off of the health systems as they are doing today.

Mr. CLAY. Thank you. The administration is attempting to justify its proposal to dismantle the FEHBP by claiming that Federal employee participation in the broader national system would immunize the Federal employee population from both the public attacks that we receive special treatment and, secondly, the related efforts to cut our benefits.

Do you think the administration makes a valid point?

Mr. TOBIAS. No, I don't. I think that we are interested—Federal employees and the amount of benefits for Federal employees is going to be attacked no matter what. And we are interested in providing basic health care through a plan together with the supplemental payments from OPM.

We are not interested in further sacrifice. And I define "further sacrifice" as continued reduced benefits or increased premiums.

So I think that the justification that the President has provided misses the mark. Maybe if the President would provide immunization from all attacks on all benefits, we might be interested. But I couldn't believe that kind of promise even if he would make it.

Mr. STURDIVANT. I think that the idea of delaying the movement of Federal employees until all of the health alliances are up and running is a sound idea and one that should spur—give some impetus to the administration to make sure that these alliances are up and running and operating well before the consideration of Federal employees going into them.

As far as immunizing Federal employees from political attacks—and I have seen—I have been around this town for a long time, and unfortunately—we have not been inoculated yet. And I don't know that we ever will be.

I think some of the things that you did, Mr. Chairman, in helping to get Hatch Act reform will help immunize Federal employees from some political attacks.

Mr. CLAY. I hope it doesn't take 20 years.

Mr. STURDIVANT. But I just don't see it. I mean basically, as we have gone through this whole process with this whole question of making the Government work better and so forth and so on, I just don't want to get ourselves in the position of somehow thinking that somebody is doing us a favor to immunize us from political at-

tacks and using that as some reasoning for something else. I just don't see any connection.

And as you know, Mr. Chairman, we have worked with the administration on some things, and we have opposed them strongly on other things. So I just don't see immunizing Federal employees from political attacks is very high up on the scope of folks who do—talk about these things.

Mr. CARTER. Mr. Chairman, if our plan is so great, then we are certainly willing to share it with the private sector. And we think that should be the trend, to come toward our plan, not go away from our plan.

In private sector, for instance, many people enjoy 100 percent of the benefits paid for, including dental and optical. We have never achieved that in the Federal Government. We pay our 70/30 ratios for health insurance, and in the private sector that would be unacceptable to many people in the private sector. We think we have a great plan, and we would like to keep it.

And I have to agree with my colleagues, we will continue to be under attack unless we find some champions to stand up for us. And we are looking right at those champions today. Thank you.

Mr. CLAY. Thank you.

Mr. VOEGTLIN. I would just have to say that if dividing our group is a way to protect them from attack, I mean it might make it harder to hit one target. But you know, we would have several smaller, weaker targets around.

So by dividing the work force and dividing the Federal employees, what they are doing is, if they say they are immunizing us, I think the converse is also true; they are opening us for attack on the benefits by breaking up one coherent voice.

Mr. CLAY. One of the main arguments for reforming the health benefit programs serving the Nation is that there are 37 million people uninsured.

In Mr. Sturdivant's testimony, he talked about as few as 160,000 Federal employees who probably have inadequate insurance and as many as 300,000 who have no insurance. Again these are Federal employees.

What do you think we should do as a committee and what the President should do in terms of dealing with those who are uninsured among our Federal work force?

Mr. STURDIVANT. Well, one of the things I said earlier is, certainly we had the problems with temporary employees, and we would like to see the administration, as part of—certainly as part of this health care reform—even though Federal employees will not go in until all of the alliances are up and running. I would like to see some immediate action to cover all of those temporary employees who have no health insurance because they are basically being exploited, and also to cover those employees who have no health insurance because they can't afford it.

It seems to me that, as far as Federal workers are concerned, before anything is done to change the existing conditions of those employees who now have insurance, it seems to me that that would be a direction to go to try to deal with some of that 37 million who have no insurance.

Mr. TOBIAS. Mr. Chairman, I think that the issue of lack of insurance coverage for Federal employees is part of the total national health care/health policy issue and that is why I believe that President Clinton ought to be applauded for raising the issue and putting it on the agenda.

We have to figure out how to get coverage for everybody in this country. We shouldn't have to have the fear and the anxiety associated with not having health care, people not—facing health problems and not having them tended to or dying as a result of not having proper health care.

So I believe that the plan that the President has introduced is something that this Congress has to grapple with in terms of providing health care coverage to those 37 million people who are uninsured.

With respect to the piece of it that affects Federal employees, our interest is that we be treated no different than those private sector employees who are already covered by health insurance and health insurance programs.

Mr. CARTER. Mr. Chairman, my feelings are that we are already paying for the cost of that care and those people out there are not receiving it. I think that is the sad part of this.

I currently have two plans. The cost for those two plans runs about $11,000 a year. I think that is inexcusable where that much money is being spent to insure me. Yet there are people out there that don't have insurance.

But even with all that money that is being spent just to provide me insurance, I don't have anything that will cover me for Alzheimer's. If I get Alzheimer's, those two plans mean absolutely nothing.

I am a disabled veteran. I can't go to the veterans hospital and stay there. They will keep me 90 days and then send me out. So there is something wrong with the system. Even though you are insured and paying astronomical fees for coverage, we still don't have adequate medical care.

I have no vision plan. I have a very limited dental plan, with all that being spent. And I know there are people out there like my grandson. He can't talk, and he can't walk. He is 10 years old, couldn't get insurance and had to fight to get SSI because of means testing. What is going to happen to that child?

These are our concerns. Every American should be covered. We support that 100 percent and I believe everybody at this table supports that 100 percent. We are paying for it now. We should have the coverage for those who need it.

Mr. CLAY. Thank you.

Are there any further questions anyone would like to pose?

Mr. Wynn.

Mr. WYNN. Mr. Sturdivant and the rest of the panel, I believe—and I am not picking on you. I believe you suggested that you thought it might be wise not to dismantle the current system for Federal employees until all of the other alliances were up in place.

I guess I am thinking politically, if, in fact, that happens and the rest of the country is moving along with a lower benefit package, doesn't that, in fact, make it more difficult to maintain the benefit level that you desire?

Wouldn't it be more desirable to try to bring the rest of the alliance benefit offerings up to the level of Federal employees?

I understand there are cost consequences of that. But I suspect that once most of the country is ambling along with partial hospitalization and without dental, it will be politically impossible for Federal employees to maintain the benefit package, whereas at this point, earlier in the process, I think at least we have the ability to argue.

What is your thinking on that?

Mr. TOBIAS. Well, I think that—go ahead, John.

Mr. WYNN. No. Any member of the panel.

Mr. TOBIAS. Go ahead.

Mr. STURDIVANT. That is a point. But it certainly is not something that—where we are now is we want these alliances to get up and running. I think there will be a debate about the level of benefits in the alliances and I think that that is where the debate should be joined.

There should not be a lower level of benefits in the alliances than Federal employees currently have. Otherwise, the promise of not having Federal employees pay more for less health care will not be met.

Mr. TOBIAS. You know, we often get caught up in the issue of politics and feasibility and so forth; but at a very practical level, it would be impossible to have a national health care plan as we have today if we phase in these alliances State by State because the way these plans are actuarially rated is based on a certain pool of employees across the Nation.

So if you are constantly extracting folks, it will be impossible to figure out what the costs of those plans will be from year to year.

So on a very practical basis, you can't have a national plan while at the same time you are moving employees out of that plan.

So I think that, on that basis alone, Chairman Clay's position of ensuring the existence of these national plans until the alliances are up and operating in each State makes good sense.

Mr. CLAY. If there are no further questions, the hearing is concluded for today.

Thank you.

[Whereupon, at 12 p.m., the committee was adjourned.]

[Additional material received for the record follows:]

PREPARED STATEMENT OF HON. FRANK R. WOLF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman, I appreciate the opportunity to outline some of my concerns about the President's health care reform proposal. The President's plan which proposes an unprecedented takeover of 14 percent of the U.S. economy will be particularly harmful to federal employees given the recommendation to abolish the Federal Employees Health Benefits Program—arguably one of the most successful health care plans in the country today.

Those who propose greater government control over medical care frequently argue that when it comes to health care, ordinary people are incapable of making intelligent decisions on what they need and want in a health care plan. Each year, during "Open Season" millions of federal employees prove these pundits wrong. From postal workers to Capital Police officers to Members of Congress and to the President—all select the health insurance package of their choice in a competitive market that offers a diverse array of plans. After 30 years of experience this plan is doing well—why destroy what is working in the health care system?

OPM announced last month that the premium increases for 1994 will average 3 percent in the FEHBP. This is just a little above the rate of inflation. In addition, over 40 percent of employees and annuitants will see decreases from 1993 premiums, according to OPM Director Jim King. In other words, the FEHBP will meet or do better—this year—than the Clinton proposal aims to do by the end of the decade.

Under the Clinton plan, the government would control one of the largest industries in the country. A national board would tell us what package of benefits Americans must have. By contrast, the FEHBP allows workers to decide for themselves which services they want included and which they do not. Federal employees are provided with reams of advice and you are no doubt familiar with the Washington Consumer's Checkbook guide which rates the plans. There are no government caps or global budgets in this plan, yet the costs are being kept down. Consumer choice is in action and it works.

Another serious cause for concern in the Clinton plan is that the proposal we have seen would only cover 80 percent of hospitalization; a dramatic loss for many federal employees who now have 100 percent hospitalization coverage. Even with a proposed cap on out-of-pocket costs in the Clinton plan, millions of federal employees could end up paying up to $3,000 more a year for events such as childbirth, general surgery or hospitalization. Efforts to allow federal employees to purchase "supplemental" plans will merely provide them with the "privilege" of paying more for what they are already getting.

A new "marriage penalty" also exists in the Clinton health plan which could be particularly onerous for families in the FEHBP who currently use only the FEHBP. One example: a self-employed wife whose husband works for the government and gets the family's health insurance from the FEHBP will now be required to pay a portion of what FEHBP previously covered. For federal employees being subject to COLA adjustments and wage freezes, this could be a large burden.

The new insurance pools that federal employees will be put into could also increase costs. Therefore the talk of the federal government picking up 80 percent of the premiums is not necessarily a better deal for federal employees until they know—80 percent of what? In discussions I have had with Administration officials, they have not been able to provide even rough estimates of what the premiums would be in the Washington area. This could very well be a big riverboat gamble for federal employees.

The government-determined "choices" in the state alliances also raise concerns. There would very likely be fewer choices than federal employees have today and if the plans were oversubscribed you would be forced into a second or third choice of plans. Those who do not get into their preferred plan would actually have to enter a "lottery" that could possibly put them in a plan that is too expensive or doesn't provide the choices they need.

The wide range of choices available under the FEHBP will not be replicated in the Clinton plan as proposed. Serious limitations are put on fee-for-service plans and the hidden and not-so-hidden price controls in the program could lead to rationing. And all of this may very well be done at a higher price than federal employees pay today! It is expected there would be a far wider disparity in costs between HMOs and fee-for-service plans than we have today. The bottom line is that for federal employees this plan as proposed could mean paying more money for fewer services and fewer choices.

Jim Cooper (D-Tenn.) has characterized the Clinton health proposal as follows: "It's so heavy-handed, so regulatory, so big government." There is no need to go this way, particularly for federal employees. The FEHBP has already done what the Clinton plan proposes to do without heavy-handed government, national and state boards and a dramatically expanded health care bureaucracy. The FEHBP is already the world's only large consumer driven group health insurance plan or "alliance" which has provided universal coverage and has already addressed many health care concerns by having no waiting periods, providing portability from one federal job to another and providing coverage of pre-existing conditions.

The track record of the FEHBP and the millions of taxpayer dollars already invested in this health care alliance should not be thrown out while federal employees are made the guinea pigs in a new and untested system. If the program isn't broken, it shouldn't be abolished. The Postal Workers plan is not being abolished, Federal employees deserve the same treatment. If there are concerns that Congress and political appointees should be in the "new" health care plan, these individuals can be put into the new system while allowing federal employees to remain in the current system.

Although the Administration is claiming to have looked to the FEHBP as a model, they went far afield from the virtues of this plan. The FEHBP is basically run by

144 employees out of the Office of Personnel Management. In contrast, the Clinton plan will require thousands of new government employees for the over 50 new bureaucracies their plan creates. Until the Clinton plan can meet or better the FEHBP (in practice, not theory), the FEHBP should not be abolished.

Abolishing the FEHBP could be a very costly mistake for the federal government as well as federal employees. The cost estimates on the Clinton health care plan are already all over the board and under fire. One White House insider has called the budget figures "a walk in space." The estimates of who will pay more range from 40 percent from HHS Secretary Donna Shalala, 15 percent from the President and Ira Magiziner at one time and the most recent figure of 30 percent from OMB Director Panetta. In the end no one can truly know the cost of dismantling something that works and trying to recreate it as part of a total overhaul of 14 percent of our economy. But to give you an idea on how wrong estimates can be consider that Medicare was estimated to cost $9 billion a year by 1990 when it was first passed and the actual cost was over $100 billion! No wonder even members of the President's own party have called the budget numbers "fantasy."

I would like to emphasize that my interest in preserving the FEHBP is not only because I represent a large number of federal employees. Actually, since redistricting last year, I represent far fewer federal employees than I have in the past. However, my knowledge and experience with the FEHBP lead me to conclude that this is not only a good health plan for federal employees, it is a good health plan for America. We should not be destroying what works already in our health care system. As the Hippocratic oath states: "First do no harm."

I have also submitted for the record an article from The Washington Post by Jim Glassman, "Uncle Sam's a Smart Buyer in One Area: Health Care."

PREPARED STATEMENT OF CAROL. A. BONOSARO, PRESIDENT, SENIOR EXECUTIVES ASSOCIATION

The Senior Executives Association is submitting the following statement concerning the Committee's November hearing on health care reform. We request that this statement be included in the hearing record.

The Senior Executives Association (SEA) recognizes a growing consensus for reform of national health care and applauds the substantial effort put forth by the Clinton Administration to develop a plan for such reform. The Post Office and Civil Service Committee hearings are a precursor to the broad range of congressional inquiry and debate which will build consensus on the precise means to accomplish health care reform.

How health care reform is accomplished is of deep concern to career federal executives, both from a personal perspective and from their perspective as managers of the federal workforce. The current Federal Employees Health Benefits Program (FEHB), as one foundation has noted succinctly, is a system which "gives consumers a wide choice of health plans and 'user friendly' advice on how to choose among rival plans. It promotes intense competition among health insurance carriers. It controls costs. It incorporates excellent benefits. And those who are enrolled in it are pleased with the system." Indeed, the foundation concluded that "Congress should adapt and refine the system that works so well for federal workers: a system characterized by consumer choice and competition."

Thus, SEA shares the Committee's concern that federal workers not be harmed by the proposal to abolish the Federal Employees Health Benefits Program. SEA also shares the concern of many employee organizations that federal workers not be subject to a reduction in choice of benefits or to increased costs for decreased benefits.

Although there is no way at present to compare benefits FEHBP members now have with coverage that would be available under the proposed standard benefit package, federal employee concerns regarding costs and benefits are not unfounded since it is estimated that 40% of the population will receive lesser benefits and/or pay a higher cost under the Administration's proposal.

The Association urges that Congress consider FEHBP as the model for the emerging national health care plan. Irrespective of whether FEHBP is utilized as a model, however, SEA recommends that FEHBP be permitted to remain intact. This can be accomplished within the framework of the Administration's proposal, which provides the latitude for large corporations to set up their own private health alliances. Similarly, federal employees could be treated within an alliance which would permit continued operation of the FEHBP, a scenario which is already envisioned for U.S. Postal Service workers.

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